COLORADO DEPARTMENT OF REGULATORY AGENCIES
OFFICE OF POLICY AND RESEARCH

COLORADO DIVISION OF INSURANCE

1996 SUNSET REVIEW

October 15, 1996

Members of the General Assembly
c/o Doug Brown, Director
Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the Colorado General Assembly:

The Colorado Department of Regulatory Agencies has completed the evaluation of the Colorado Division of Insurance. We are pleased to submit this written report, which will be the basis for my office's oral testimony before the 1997 Legislature. The report is submitted pursuant to Section 24-34-104 (8)(a), of the Colorado Revised Statutes, which states in part:

> *"The department of regulatory agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...*
>
> *The department of regulatory agencies shall submit a report and supporting materials to the office of legislative legal services no later than October 15 of the year preceding the date established for termination . . ."*

The report discusses the question of whether there is a need for the regulation provided under title 10, C.R.S. The report also discusses the effectiveness of the division and staff in carrying out the intention of the statutes and makes recommendations for statutory and administrative changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

Joseph A. Garcia
Executive Director

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EXECUTIVE SUMMARY

The Department of Regulatory Agencies has concluded its 1996 Sunset Review of the regulation of the insurance industry by the Colorado Division of Insurance (DOI). The Department found there is a need for continued regulation of the industry and recommends that the DOI continue to serve as the state regulatory agency. In evaluating the operation of the DOI against the Sunset Evaluation Criteria in §24-34-401.1, C.R.S., the Department found several areas where statutory changes are necessary to remove impediments or enhance the DOI's ability to operate in the public interest. A total of nineteen statutory and four administrative recommendations are contained in the Sunset Review.

Each recommendation is followed by a brief summary and an expanded discussion of the analysis and issues surrounding the recommendation. A single discussion section is used when several recommendations are on a single topic area. The recommendation section begins on page 59 of the report.

Industry and consumer representatives contacted for input on the report were supportive of continued regulation by the state and generally supportive of the operation of the DOI. Colorado is lacking an organized consumer group with an emphasis in insurance issues. While the mission of DOI is consumer protection, this report finds the DOI cannot function as both an advocate and a regulator. Therefore, a major recommendation of this report is for the creation of an independent consumer advocate for insurance issues within the Office of Consumer Council.

Colorado has more consumer complaints and fewer formal enforcement actions than comparable states both regionally and nationally. This fact leads to recommendations to increase enforcement and market conduct resources.

In order to reduce unnecessary administrative actions against bailbonds producers, this report recommends that the courts implement procedures to reduce bailbond forfeitures. In an effort to streamline the sunset process, an additional recommendation changes the sunset date for the bailbond program to coincide with the next DOI sunset review.

Three recommendations are made in the area of automobile insurance. They are: 1) transfer responsibility for permitting self insured fleets to the DOI; 2) establish a computerized uninsured motorist database; and 3) replace the monetary threshold for noneconomic tort recovery to a verbal threshold.

The report makes three recommendations relating to Worker's Compensation Insurance. Two recommendations bring the regulation of the Colorado Compensation Insurance Authority under standards similar to those imposed on other Workers Compensation insurance companies. The other recommendation would require self-insured entities to report claims data to the DOI.

Recommendations change Health Maintenance Organizations (HMO) rate filing and financial examination frequency requirements so that they are similar to other lines of insurance.

Other statutory recommendations will: authorize monetary penalties for noncompliance with financial solvency standards; authorize premium tax audits; repeal the statutory authorization for the use of credit history in underwriting; bring the credit insurance loss ratio into line with other states; and allow the Commissioner to establish underwriting criteria for homeowners insurance.

The report makes administrative recommendations for the Commissioner. It recommends that the Commissioner develop legislation to prevent underwriting discrimination against victims of domestic violence. Additional recommendations include: reduce fees for certain administrative services charged to licensed producers; establish an objective, measurable, evaluation of the mandatory continuing education program for producers; and devote additional resources to the collection of premium taxes.

BACKGROUND

Introduction

Insurance plays an important role in our society. The use of insurance dates back to antiquity. Put simply, it provides a financial safety net for unanticipated consequences. A buyer will enter into a contract with an insurer whereby the buyer pays a premium to the insurer which is equal to a small amount of the insured item. This ensures that if the item is damaged or lost, its value is replaced. In one sense insurance can be seen as a gamble. By purchasing insurance, the buyer bets that the insured item will be damaged or lost. Even if not damaged or lost, the buyer is comfortable knowing that he or she will not lose everything in the event of an unforeseen consequence. The seller is betting either that the item will not be damaged, or that sufficient premiums will be collected from a large enough pool that they offset any payout.

Today, the role of insurance has grown considerably. It permeates every facet of our lives. In many cases, insurance is statutorily required. Various professions require an individual to hold errors and omissions insurance, and owners of automobiles must obtain liability insurance. The free market has evolved to the point where in order to participate in various business and commercial transactions, insurance is mandatory. For example, most individuals may not obtain a mortgage for a home without having insurance, even when using a private lender.

Insurance in Colorado is one of the largest industries in the state. The gross direct written premiums in the state exceed $13 billion and continue to grow. The premium tax alone raised $107 million for the State of Colorado in 1994. In 1994, Colorado ranked 23rd in the United States in premiums collected. The Colorado Division of Insurance (DOI) ranked 25th in budget and was in the bottom third in terms of staff size.

From a consumer product view, insurance may be divided into the following categories: 1) Life and Health, and 2) Property and Casualty. In addition to oversight of traditional insurance business, the DOI regulates non-insurance products, such as bail bonds and preneed funeral contracts (prepayment of funeral services).

The Colorado General Assembly has determined that market forces alone do not protect the public from potential insurance misuse and fraud. The complexity of insurance makes it very difficult for the public to adequately protect itself without government regulations. Consequently, the DOI within the Department of Regulatory Agencies (DORA) regulates insurance. Its task is to provide oversight that protects the public from unstable insurance companies and illegitimate insurance products with minimum interference to the insurance market. Overregulation will make it unfeasible for insurance companies to operate in the state, and underregulation will leave consumers vulnerable to abuse. As a result of this dichotomy, regulation of the industry must maintain a delicate balance between encouraging competition and protecting the public.

An insurance contract is a promise by an insurance company to cover a future loss in return for premium payments by a policyholder. If the insurance company is unable to perform the obligation when it arises, the policyholder faces a triple loss:

- The loss of the premium dollars paid to the insurance company,
- The loss of the benefit of the coverage by the insurance company, and
- The loss which triggered the payment obligation of the insurance company.

To prevent such a hardship, it is necessary to protect the health of the insurance industry while at the same time encouraging competition among the insurance companies. The legislative declaration to the Colorado Insurance Code (§10-1-101, C.R.S.) identifies this theme:

> *The General Assembly finds and declares that the purpose of this title is to promote the public welfare by regulating insurance to the end that insurance rates shall not be excessive, inadequate, or unfairly discriminatory, to give consumers thereof the greatest choice of policies at the most reasonable cost possible, to permit and encourage open competition between insurers on a sound financial basis, and to avoid regulation of insurance rates except under circumstances specifically authorized under the provisions of this title. Such policy requires that all persons having to do with insurance services to the public be at all times actuated by good faith in everything pertaining thereto, abstain from deceptive or misleading practices, and keep, observe, and practice the principles of law and equity in all matters pertaining to such business.*

Under this declaration, the DOI is charged with "encourage(ing) open competition between insurers" while at the same time seeking to regulate in such a manner that insurance rates are not "excessive, inadequate, or unfairly discriminatory." The bifurcated regulatory charge of the DOI creates a difficult balance to maintain. There is an inherent conflict between the roles of insurance consumer advocate and guarantor of insurance industry solvency.[1] DOI staff must balance the interests of the consumer and the industry, which at times can be difficult.

History of Insurance Regulation in Colorado

Insurance regulation has been a matter of state concern since the U.S. Supreme Court decision Paul v. Virginia, (8 Wall. 168, 1869). The Supreme Court held that transactions in commerce did not include the issuance of insurance policies. Therefore, transactions in insurance would not fall under the Interstate Commerce Clause of the United States Constitution. As a result, insurance regulation became the responsibility of the states. Reacting to the Paul decision, several states, led by New York and Maryland, formalized insurance regulation by creating state regulatory agencies.

In 1871 the existing state insurance regulatory authorities formed what became the National Association of Insurance Commissioners (NAIC). Originally designed to assist state insurance regulators, it coordinated the supervision of multi-state companies. Today, the NAIC has become the national repository of insurance policy and statistical information, and provides valuable support services to state insurance regulators. The scope of these services is discussed later in various sections of this report.

In 1944, the U.S. Supreme Court reversed Paul v. Virginia in U.S. v. South-Eastern Underwriters Association, 322 U.S. 533, (1944). The decision that insurance was commerce and therefore subject to interstate regulation by the federal government raised concerns of a new federal bureaucracy. Congress responded to these concerns with the passage of the McCarran - Ferguson Act in 1945. The Act affirmed the authority of Congress to preempt the state from the regulation of insurance. However, it recognized that each state already regulated insurance and that the exercise of federal power in this area was unnecessary. Under the Act, the federal government's authority to regulate insurance is held in abeyance as long as the states effectively regulate the industry. The Act also effectively exempts insurance companies from federal antitrust laws and Federal Trade Commission regulation, although recent court cases have narrowed these exemptions.

[1] Colorado State Auditor's Office, Performance Audit of the Division of Insurance, 1989 .

Colorado began to regulate insurance through the State Auditor's Office in 1883. The Colorado Department of Insurance was formed in 1913 in response to widespread growth in the industry. In the mid-1960s the Insurance Department became part of the Colorado Department of Regulatory Agencies as the Division of Insurance (DOI). The head of the DOI is the Commissioner of Insurance, appointed by the Governor and confirmed by the Colorado Senate.

The DOI regulates 72 domestic and approximately 1600 foreign insurance companies licensed or authorized to conduct business in Colorado. Companies may also write insurance in the state as an authorized but unlicensed company by submitting financial information to the DOI Corporate Affairs section and receiving approval.[2] Legislation in 1993 consolidated several types of Insurance Agent and Broker Licenses into a Single Insurance Producer License, effective January of 1995. The DOI licenses approximately 35,000 insurance producers.

In addition to the regulation of insurance companies and producers, the DOI has several programs not traditionally linked to insurance regulation. Examples include preneed funeral contracts and premium tax collections.

Insurance History Timeline

The following timeline provides a brief history of significant dates within the State of Colorado's regulation of insurance.

1883 Colorado begins to regulate insurance companies through the State Auditor's Office.

1913 Department of Insurance is created, Commissioner compensation is $3000/year, Actuary/Deputy $2400/year, Stenographer $1200/year.

1947 Colorado General Assembly establishes rate regulation standard of "not excessive, inadequate, or discriminatory."

1953 Insurance Commissioner is authorized to regulate preneed funeral sales.

1963 Proof of financial responsibility at the time of a personal passenger automobile accident is mandatory.

[2] Authorized companies usually provide a rare surplus insurance product offered only by a few companies and do not have offices in the state. For a more detailed discussion of surplus lines insurance companies, see page 9.

1969 Insurance Commissioner is authorized to regulate credit insurance.

1968 Department of Insurance moved into DORA as Division of Insurance.

1974 Colorado adopts mandatory no-fault auto insurance law.

1978 A State Insurance Board is established, with the authority to overturn the Commissioner on rules, regulations, and rates.

1985 Insurance Board is repealed.

1991 Workers' Compensation reform, Division of Workers' Compensation is created in the Department of Labor and Employment.

1993 General Assembly adopts the "single producer license" concept for agent licensing.

SUMMARY OF STATUTE

Title 10 of the Colorado Revised Statutes encompasses most of the regulatory statutes on insurance. Title 10 outlines the powers and duties of the Division of Insurance as well as identifies the responsibilities of insurers under different lines of insurance. The following outlines each article under Title 10 and describes the various types of insurance regulated by Colorado.

Art. 1 General Provisions

This article establishes the qualifications and duties of the Commissioner and Actuary. It grants the Commissioner rule-making authority and authorizes the Commissioner or designees to conduct examinations of insurance companies. Companies underwriting specifically identified malpractice insurance are required to report claims to professional licensing boards under this article.

Art. 2 Licenses

In 1993, the "Single Producers Licensing Act" extensively overhauled the statutory provisions for licensing insurance agents. Article 2 contains the education and examination requirements individuals must comply with to be licensed to sell any type of insurance in Colorado. The DOI issues a single license to insurance producers (formerly called agents) with individual authorizations to sell different types or lines of insurance. Article 2 also addresses prelicensure and continuing education, appointment of insurance producers, nonresident licenses, authority of banks and bank holding companies to sell insurance, business conduct of licensees, disciplinary actions, reinsurance intermediaries, and managing general agents.

Art. 3 Regulation of Insurance Companies

Article 3 and the regulations adopted to implement it are the most important and complex public protection aspect of the insurance code. This article governs the formation of insurance companies and regulates the officers of the companies, defines investment limitations and valuation, prohibits certain high-risk investments, and authorizes the collection of premium taxes. Uniform guaranty deposit provisions require some foreign and alien insurers to place a deposit with the Commissioner to provide some security to Colorado policy-holders.

Parts 4 and 5 authorize the Commissioner to implement remedial action on delinquent or insolvent insurers. These actions can include placing a company on probation, direct supervision, receivership, or liquidation.

Article 3 contains the Commissioner's authority to regulate reinsurance, insurance holding companies, and the exchange of insurance securities, including the acquisition or merger of insurance companies. This article also identifies unauthorized insurance practices and remedies for violations. Key components in the article are the unfair competition and deceptive practices provisions. The final provisions are the model quality replacement parts act, concerning auto repairs, and the model risk retention act, dealing with risk retention and purchasing groups.

Art. 4 Property and Casualty

Most citizens are covered under one or more property and casualty insurance (P&C) policies in their everyday lives. Typical insurance in this category includes auto, homeowners, title, renters, malpractice, product liability, commercial liability, Workers' Compensation, and many other product lines. To protect consumers, the general provisions of Article 4 require prior notice of cancellation for certain policies. Colorado requires prior approval for certain insurance policy rates. However, rates for most lines of insurance may be used after filing required information with the Commissioner. This section of the statute contains criteria for review and approval of rates. It also identifies requirements for bonds for surety companies, medical malpractice, and commercial liability joint underwriting associations. Mandatory automobile insurance coverages and the no-fault insurance act, which impact most Coloradans, are contained in this article. Additionally, Part 10 is the "Fraudulent Claims and Arson Information Reporting Act." One of the most significant consumer protection features of Article 4 is the "Colorado Insurance Guaranty Association Act," which provides a safety net for policyholders of insolvent insurers.

Art. 5 Surplus Line Insurance

Surplus line insurance is usually a highly specialized or high risk liability product. When a consumer is unable to obtain insurance from companies licensed in the state, an insurance broker may place the risk with a company licensed in another state but authorized to do business in Colorado. In order to be authorized, the company must comply with Colorado insurance laws regarding capital, surplus, and reserves. Common surplus line insurance purchased in Colorado includes environmental liability, some product liability, errors and omission, professional liability, director's and officer's liability, and other specialized liability coverages. Colorado began regulating surplus line insurers in 1949.

Art. 6 Captive Insurance Companies

A Captive Insurance Company is a company established by a company or group to write insurance for the specific company or group. Large employers may create these companies to underwrite benefit plans for their employees. It is a more sophisticated form of self-insurance for large employers. Captive insurance companies are not required to participate in guarantee pools, nor are they eligible to receive relief from a guarantee pool.

Art. 7 Life Insurance

Life insurance, in its pure form, is the easiest insurance product to understand. An insured pays a premium with the understanding that his or her named beneficiaries will receive a specific lump sum payment upon the death of the insured. There are many types of life insurance products: term, whole life, universal life, and annuities. Term life insurance is the basic product, a death benefit. The other products have value-added features such as cash value or equity building that give them value as “savings” plans. The state has overseen life insurance companies since the beginning of insurance regulation. Section 10-7-102, C.R.S., identifies requirements for life insurance policies sold in Colorado.

Art. 8 Sickness and Accident Insurance

Article 8 addresses the issue of access to health insurance for consumers. Part 5 of the article creates the "Colorado Uninsurable Health Insurance Plan” (CUHIP). The statute, in §10-8-504, C.R.S., states CUHIP “is an instrumentality of the state; except that the debts and liabilities of the plan shall not constitute debts and liabilities of the state and neither the plan nor the board shall be an agency of state government.” CUHIP provides insurance for those who are denied access from the public sector. CUHIP offers insurance to individuals who for some reason (usually a preexisting condition) are not eligible for private insurance at a reasonable premium. CUHIP’s premiums are limited to 175 percent of private insurance premiums.

Part 6 of Article 8 is the “Small Employer Health Insurance Availability Program Act.” This act requires insurance companies writing health insurance plans for small businesses to offer specific benefit packages to groups as small as one and limits the ability of insurance companies to deny coverage to individuals in the group.

Art. 9 Franchise Insurance

Repealed, 1995

Art. 10 Credit Insurance

"Credit insurance means insurance on a debtor to provide indemnity for payments or loan balance, or any combination thereof, becoming due on a specific loan or other credit transaction upon the occurrence of a contingency for which insurance is obtained" (§10-10-103(2), C.R.S.). A common form of credit insurance is a declining benefit term life policy to pay a home mortgage in full upon the death of the mortgagee. Credit insurance is also available for auto loans and credit card balances. The product can be a death benefit, or structured to make loan payments in the event of disability, illness, or unemployment.

Art. 11 Title Insurance

Title insurance is a specialized product designed to indemnify, or protect, purchasers of real property from defects or claims against the title to the property. Title companies research assessor and court records for liens and other interests against the property, provide the prospective purchaser with the information, and are involved in the "closing" of the real estate transaction.

Art. 12 Mutual Insurance

A mutual insurance company may be formed by an association of 100 or more individuals for the purpose of providing insurance to members. Mutuals operate in a manner similar to credit unions, in that policyholders become voting members of the mutual insurer. Members share in the profits of the insurer and select the board of directors, who are responsible for hiring the insurance management staff.

Art. 13 Interinsurance

Article 13 regulates the formation of a reciprocal insurance exchange. This unique type of entity is an unincorporated group of individuals, called subscribers, who mutually insure one another, each assuming a portion of the others' risks. The most famous example of an exchange is Lloyds of London. Farmers Insurance Exchange is the best-known interinsurer licensed in Colorado.

Art. 14 Fraternal Benefit Societies

§10-14-102, C.R.S., defines "Any incorporated society, order, or supreme lodge, without capital stock, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides any of the benefits enumerated in §10-14-401, C.R.S., is hereby declared to be a fraternal benefit society." Fraternal benefit societies differ from mutual associations in that they may have different classes of members and not all members necessarily have the ability to vote on issues relating to insurance benefits.

Art. 15 Preneed Funeral Contracts

Preneed contracts are not insurance; they are essentially trusts, regulated by the DOI. Preneed contracts are agreements to provide funeral, interment, entombment, or cremation merchandise or services in the future for an agreed-upon fee. The legislative declaration of §10-14-101, C.R.S., indicates the General Assembly desires to protect the public from unconscionable dealings by individuals in this field, and Article 15 establishes the authority for the DOI to regulate this activity.

Art. 16 Health Care Coverage

Article 16 is the Colorado Health Care Coverage Act. Part 1 of the act contains the general provisions including mandatory coverages, small group guarantee issues, marketing standards, and limitations on exclusions for preexisting conditions. Part 2 contains the provisions for the regulation of individual sickness and accident insurance policies. Part 3 deals with nonprofit hospital and service providers. Part 4 provides for the establishment and regulation of Health Maintenance Organizations (HMOs). Part 5 authorizes and regulates prepaid dental care plans.

Art. 17 Health Maintenance Organizations

Repealed, 1992, incorporated into Article 16.

Art. 18 Medicare Supplement Insurance

Medicare supplement insurance is "gap" insurance. That is, it indemnifies policyholders against expenses in excess of the benefits provided by the federal Medicare program. Policies are regulated in Colorado to prevent duplication of coverage and termination of coverage should a policyholder's health deteriorate. Medicare supplement policies are standardized to a great degree under this act.

Art. 19 Long-Term Care

Long-term care insurance as defined in §10-19-103(5), C.R.S., “means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. "Long-term care insurance" includes group and individual annuities and life insurance policies or riders that provide directly or that supplement long-term care insurance....” All companies writing long term care insurance must offer both a basic and a standard policy containing benefits approved by the Commissioner

Art. 20 Life and Health Insurance Protection Association

This article was established in 1991 to create the Life and Health Insurance Protection Association, a state guarantee pool. Membership in the association is mandatory for all life and/or health insurance companies licensed in Colorado. The association's purpose is to provide a safety net for policyholders of insurance companies that become insolvent. The association is funded by fee assessments made on each member. Assessments are used to cover operating expenses of the association and to provide financial relief to policyholders of insolvent insurance companies, subject to the limits imposed by the statute and the members of the association.

Art. 21 Health Care (cont.)

The Colorado Care Health Insurance Program was authorized first as a study of the cost and availability of health insurance to Colorado citizens. Article 21 authorizes the Executive Director of the Department of Health Care Policy and Financing to establish pilot programs implementing the recommendations of the Colorado Care study.

OVERVIEW OF THE COLORADO DIVISION OF INSURANCE

Organization of the Division of Insurance

The head of the Division of Insurance, the Commissioner of Insurance (Commissioner) is appointed by and serves at the pleasure of the Governor, subject to approval of the appointment by the Senate. The Commissioner is one of the few nonelected state officials required to take an oath prior to assuming office. The Commissioner has broad responsibility to enforce the insurance laws in Colorado.

Following the 1989 State Auditor's Report and the 1990 DOI Sunset Report recommending a more efficient and consumer oriented division, the DOI was reorganized into three main areas of responsibility:

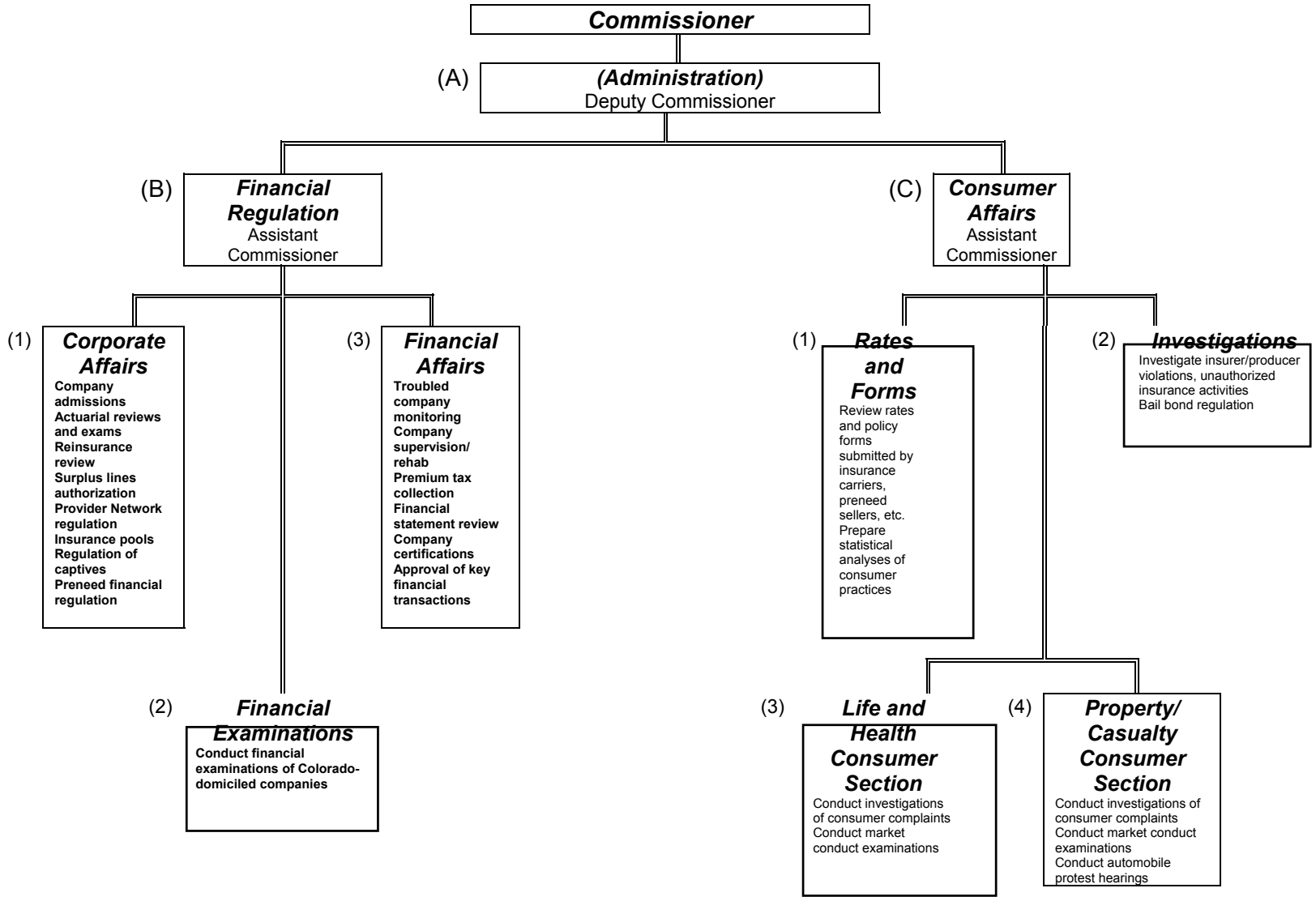
A) Administration

B) Consumer Affairs

C) Financial Regulation

An Assistant or Deputy Commissioner supervises each of these areas, which is further broken down into key subsections. (See organizational chart on page 15.) The following pages outline the responsibilities of these areas.

Colorado Division of Insurance
Table 1



A. ADMINISTRATION

Administration is the direct responsibility of the Deputy Commissioner of Insurance. In addition to basic operation duties such as budgeting, purchasing, records management, the Deputy Commissioner supervises the licensing and renewal of insurance producers. Currently, there are 35,000 licensed producers in the state. This section also coordinates legal services with the Attorney General's Office and monitors all bills in the Legislature that potentially impact the Division of Insurance. Finally, this section is very involved with policy-making in the health insurance area.

B. FINANCIAL REGULATION

Responsibility for financial regulation falls under the supervision of the Assistant Commissioner for Financial Regulation. Regulatory activities are divided into three sections:

1) Corporate Affairs

2) Financial Examinations

3) Financial Affairs

Below is a brief summary of the activities of each of these sections.

1. CORPORATE AFFAIRS SECTION

The Corporate Affairs Section of the DOI is responsible for examining insurance companies to determine whether they meet the requirements of Colorado law for writing insurance in the state. The DOI employs actuaries in this unit to determine whether insurance companies have sufficient reserves to cover the risks the companies are agreeing to assume. They are also responsible for regulating reinsurance activities and actuarial reviews. This section monitors captives, insurance pools, and preneed funeral sellers. Additionally, the Corporate Affairs Section reviews mergers, acquisitions, and applications for company licensure.

2. FINANCIAL EXAMINATIONS SECTION

The Financial Examinations Section is responsible for conducting examinations (audits) of insurers licensed to do business in Colorado. Examinations encompass the review, verification, and documentation of company records to ensure that they meet proper asset, reserve, and other financial statutory requirements to ensure solvency. Depending upon the statutory requirements, the Financial Examinations Section performs examinations on companies every three to five years. The focus of the unit is on domestic insurance companies, since foreign companies are examined by their state of domicile. Reports on such examinations (as well as those produced by the DOI) are shared between the states and used for regulatory purposes. Authorization for these examinations is pursuant to §10-1-200, C.R.S., et seq.

3. FINANCIAL AFFAIRS SECTION

The Financial Affairs Section monitors the financial condition of approximately 1600 insurance companies admitted to do business in the state. This section is responsible for oversight of any solvency problem associated with a domestic insurance company. The Financial Affairs Section also collects, deposits, and verifies the annual premium tax collections and fees in Colorado, which amounted to $107 million in 1995. Premium tax collections are the third-largest source of state-generated revenue to the general fund, behind income and sales taxes.

C. CONSUMER AFFAIRS

Consumer Affairs reviews all consumer complaints and works to resolve them in cooperation with the insurance carriers. The Assistant Commissioner of Consumer Affairs oversees the responsibilities of this area. Consumer Affairs investigates all lines of insurance complaints and in 1995 handled approximately 8000 written complaints and 65,000 telephone inquiries.[3] Additionally, Consumer Affairs reviews insurance company rates and forms to ensure that they comply with Colorado statutes, and performs market conduct examinations.

[3] Statistics provided by the Colorado Division of Insurance

The Consumer Affairs section of the DOI is responsible for enforcing specific language within the statutes designed to protect consumers. Under §10-1-111(1), C.R.S., the Commissioner is authorized to revoke or suspend a company's certificate of authority for any reason specified in Title 10, Article 7 of Title 12 (dealing with bail bondsmen), and Article 14 of Title 24 (dealing with liability insurance of state and county employees), and for :

> *(h) Use of methods which, although not specifically proscribed by law, nevertheless render its operation hazardous or its condition unsound to the public or to its policyholders;*
>
> *(I) Failure to otherwise comply with the law of this state, if such failure renders its operation hazardous to the public or to its policyholders.*

Additionally, the Unfair Trade Practices Act, §10-3-1104, C.R.S., defines unfair methods of competition and unfair or deceptive acts or practices in the business of insurance in Colorado. Section 10-3-1108, C.R.S., authorizes the Commissioner to order monetary penalties, suspension or revocation of a license, or payment of a claim for any violation of this act.

The Consumer Affairs Section divides regulatory activities within their section into four areas:

1. Rates and Forms
2. Investigations
3. Life and Health
4. Property/Casualty.

Following is a summary of the functions of each of these sections.

1. RATES AND FORMS

When an insurance company is initially approved to sell products in Colorado, it submits for approval copies of all policies and the rate structure for each policy to the Rates and Forms Unit. The unit reviews the policies (Forms) to ensure they comply with Colorado laws, such as mandatory coverages and renewal provisions. The unit also evaluates rates to ensure they are not excessive, not inadequate, or not discriminatory. Once established in Colorado, a company does not generally need prior approval for new products. However, the company is still required to submit any new offered products to the unit for review.

The company must also submit any new rates to the unit. All rates are subject to the same requirements that they are not excessive, not inadequate or not discriminatory. Most rates are certified as being in compliance by the issuing company and may be used when filed. Rates for some lines of insurance, Medicare supplement, Workers' Compensation loss costs, and credit insurance, require approval from the Commissioner prior to being used.

2. INVESTIGATIONS

The Investigations Unit is responsible for determining if licensed producers have violated insurance statutes or regulations. This unit also investigates complaints regarding the sale of insurance issued by unauthorized entities.

Investigations by the unit sometimes result in enforcement actions against producers or unauthorized companies. In situations involving fraud or other criminal conduct, or in the case of unauthorized companies, the unit works with local district attorneys and federal enforcement agencies to pursue criminal prosecutions.

3. LIFE AND HEALTH

The Life and Health Unit is responsible for resolving consumer issues related to life and health insurance. The unit receives and investigates consumer complaints involving mandatory coverages, rate and coverage changes, and claims payments. Life and health insurance companies are subject to market conduct examinations by this unit. Market conduct examinations may target a specific company practice or cover a broad range of issues including marketing practices, premium rates, claims procedures, and policy coverages.

4. PROPERTY/CASUALTY

The Property/Casualty unit is responsible for resolving consumer issues related to property and casualty insurance. The unit receives inquiries and investigates consumer complaints involving mandatory coverages, rate and coverage changes, claims payments, and conducts automobile protest hearings. Property and casualty insurance companies are subject to market conduct examinations by this unit. As with the Life and Health Unit, a market conduct examination may target a specific company practice or cover a broad range of issues.

Additionally, within the Consumer Affairs Section, is the responsibility for hearing Workers' Compensation Classification Appeals. In this situation, the consumer is the business purchasing Workers' Compensation Insurance for employees. The insurance company classifies workers by job description and assigns an approved rate to the particular job classification. If an employer is unable to resolve a dispute with the insurance company classification, an appeal is filed with DOI. An improper classification can result in a substantial cost to the employer.

THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC)

Under the McCarran-Ferguson Act of 1945, the authority of the federal government to regulate insurance was delegated to the states. The act provides that the federal government will not regulate the insurance industry if states choose to do it instead. Today, the states provide the primary regulation of the insurance industry. Consequently, most insurance companies must be licensed and are regulated by every state in which they do business, although primary financial oversight and examination responsibilities rest with the insurance commission of the state where the company is domiciled. The absence of federal oversight coupled with regulatory responsibility by the states created a need for a national presence to assist in coordinating state regulations and to promote communication among states to provide regulatory guidance to the insurance community. The National Association of Insurance Commissioners (NAIC) is that national presence. Composed of state insurance regulators, this voluntary association helps coordinate regulatory activities and assists state officials in performing their tasks. Membership to the NAIC is automatic for all states, and every state actively participates.

Accreditation

In response to the insurance insolvency crisis in the late 1980s and a subsequent Congressional investigation, the NAIC developed national accreditation standards for state regulatory programs. A team of NAIC auditors reviews state programs to determine if the state meets the standards for accreditation. The Association accredits states that meet statutory and regulatory criteria and that maintain resources to enforce them. Colorado was one of the first states accredited when the program began in the early 1990s. Originally, the accreditation program was hailed as a panacea for insurance solvency and federal oversight woes. However, several states have since hesitated at some of the requirements to become accredited and have threatened retaliation against insurance companies domiciled in other states if other states enforce sanctions against their domestic insurance companies. Forty-seven states are accredited by the NAIC, with New York, Nevada, and Hawaii the only three that are not. Accreditation, however, is not synonymous with a strong regulatory program because New York has one of the strongest in the country. New York accreditation was removed when the state legislature rejected key legislation required by NAIC for accreditation. This has weakened the uniformity of the NAIC program, but supporters argue solvency standards are improving nationally.

As a purely private organization, the NAIC has no enforcement authority and depends upon voluntary cooperation of the states in achieving its goals. However, in order for a state to achieve the NAIC's accreditation, the state legislature must pass certain legislation regarding the regulation of insurers. Additionally, the state regulatory agency must also meet requirements regarding regulatory practices and procedures, and organizational and personnel procedures. Consequently, critics have condemned the NAIC as being both too strong and too weak.

On the federal level, some Congressional leaders have concluded that the NAIC's lack of authority prevents any ability to mandate states into tighter regulatory oversight. Since decisions by states to adopt NAIC model legislation are voluntary, in order to reach a consensus, the NAIC compromises on tighter restrictions. Some believe that a federal agency would eliminate that problem, thereby ensuring better consumer protection. An example of this compromising is the accreditation procedures developed by the NAIC.

At the state level, some legislators believe that the NAIC should not have the authority to require insurers to provide information to a private organization nor should the NAIC require states to adopt certain regulations for accreditation. They feel that the NAIC exceeds its authority and have suggested legislation in the past to reduce the role of the NAIC in state insurance regulation. However, it is the prerogative of the legislature to adopt NAIC model legislation, as recommended, with modifications, or not at all. Some states, with excellent regulatory programs, (New York, for example) have declined to adopt legislation required for accreditation and the repercussions have been minimal.

Within Colorado, industry critics of the NAIC and DOI complain that the DOI adopts broad interpretations of NAIC model regulations when the General Assembly passes a model bill. It must be noted that the state Administrative Procedures Act (APA) provides for an open process and requires the Commissioner to consider evidence from the industry before promulgating a regulation. The APA also provides for an appeals process directly to the Legislature if critics believe a regulation exceeds the authority of statute. This appeals process has not been used; therefore, modifications of the Commissioner's authority to promulgate regulations does not seem necessary at this time.

Regardless of the view of the NAIC, the composition of the NAIC promotes the opportunity for states to gather and disseminate information about insurance companies and for greater conformity in regulatory oversight.

The State of Colorado has a very strong presence in the NAIC. The Commissioner is a member of many committees and task forces including Examination Oversight, Consumer Participation Board of Trustees, Accident Health Insurance Committee, and the State and Federal Health Insurance Task Force. Additionally, other agency personnel within the DOI sit on various NAIC task forces and working groups which develop new guidelines for enforcement and regulatory oversight.

NAIC Assistance

The DOI relies heavily on NAIC tools to assist in its regulatory oversight of insurance companies. When applicable (i.e., not statutorily prohibited or not as strong as state requirements), the state enacts NAIC-proposed guidelines in an effort to maintain a high regulatory presence. Additionally, the NAIC provides various national databases which allow the DOI to monitor financial status and trends as well as complaints and enforcement actions against insurers. Below is a summary of NAIC tools used by the DOI in its regulation of the industry.

Accreditation

NAIC, at the state's request, will perform an on-site preliminary review to help states assess its compliance for accreditation. NAIC will also review legislative bills to help assess whether they meet current accreditation requirements.

Through accreditation, the Colorado consumers are assured that other states have specific regulatory standards for their domiciled insurance companies which may be licensed and conducting business in Colorado. Without these standards, the DOI would need to conduct independent examinations of companies in nonaccredited states.

Market Affairs/Investigations/Enforcement/Complaints/Licensing

The NAIC provides a number of on-line databases to assist states in identifying and communicating with other states about their regulatory actions and complaints against insurance companies and producers. State insurance regulators may use these databases to assist in claims handling, advertising and marketing, producer and company licensing, company management, and consumer information. For example, state regulators may prevent violators from obtaining licenses in multiple states by searching the databases prior to granting a license. Other databases report on complaints and activities of market conduct concerns. The following are a few of the databases provided to the states by the NAIC:

- Regulatory Information Retrieval System (RIRS) - contains the names of producers and companies that have been subject to formal regulatory or disciplinary action.

- Special Activities Database (SAD) - contains firms and individuals that have had charges brought against them, have been the object of specific investigation, or have been reported to be involved in fraudulent, unlicensed, or unauthorized activity.

- Complaint Database System (CDS) - consists of aggregated consumer complaint data from insurance departments.

- Producer Database (PDB) - tracks information on all producers involved in the business of insurance.

Additionally, the NAIC provides financial monitoring assistance such as their Financial Analysis Workboards and the Examination Jumpstart program. In summary, NAIC provides valuable tools to help state regulators enforce insurance statutes. Ultimately, the health of the insurance industry and the effects on consumers lies squarely on the shoulders of the states. The NAIC has no direct regulatory authority over insurance companies. However it disseminates information and provides support to states' regulatory programs. Due to each state's reliance upon the other to regulate the insurance industry, constant communication with each other is the only way that a program of this nature can be effective.

STRUCTURE AND FUNCTION OF THE COLORADO DIVISION OF INSURANCE

Under §10-1-103, C.R.S., the Division of Insurance oversees " the execution of the laws relating to insurance, and has a supervisory authority over the business of insurance in this state."

Section 10-1-102(7), C.R.S., defines insurance as:

> *a contract whereby one, for consideration, undertakes to indemnify another or to pay a specified or ascertainable amount or benefit upon determinable risk contingencies, and includes annuities.*

The DOI complies with its statutory duties through an elaborate regulatory process that provides oversight of the insurance industry through varying levels of monitoring. This monitoring helps ensure the dual role of responsibilities of the DOI to protect the public welfare and encourage open competition within the insurance industry.

Duties of the Commissioner

The Commissioner has broad responsibility to enforce the insurance laws in Colorado. The Commissioner must maintain permanent records of administrative and rule-making proceedings and keep open records concerning the financial condition of regulated insurance companies; examine all requests and applications for licenses; and refuse to issue any license until the Commissioner is satisfied with the qualifications of the applicant.

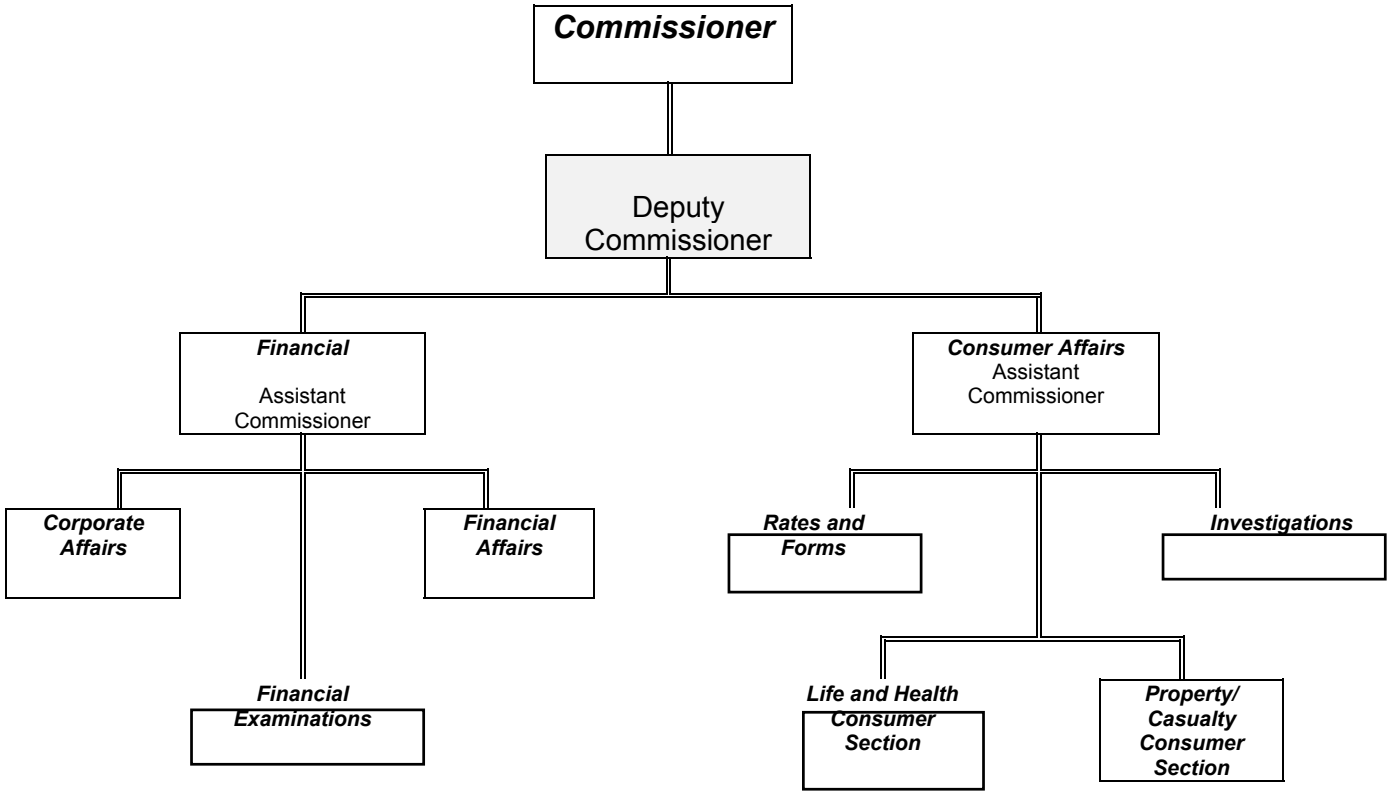
The duty of the Commissioner is best summarized by §10-1-108 (8), C.R.S.

> *It is the duty and responsibility of the Commissioner to supervise the business of insurance in the state to assure that it is conducted in accordance with the laws of this state and in such a manner as to protect policyholders and the general public.*

Functions Of The Division Of Insurance

As explained earlier in the report, functions of the Division of Insurance may be divided into three areas: A) Administration, which provides Division management, tracks legislation related to insurance, and administers producer licensing, B) Financial Regulation, which approves company operations in the state and monitors solvency, and C) Consumer Affairs, which responds to consumer complaints and performs market conduct examinations. All three are integral to the regulation of the insurance industry. See page 15 for an organizational chart.

A. ADMINISTRATION



A. ADMINISTRATION

Producer licensing

Since 1995, the DOI has implemented a single producer licensing scheme to regulate agents who sell insurance. Prior to that time, an agent had to obtain separate licenses for each category of insurance sold (e.g., property and casualty, life, health) in addition to separate licenses as an agent and/or broker**.** Now all agents and brokers are classified as producers and require only one license. Any producer acquiring the qualifications to sell a new line of insurance results in a producer's license being amended rather than in the producer being issued a separate new license. This single producer licensing scheme provides easier administration of the licensing program because the DOI and the producer must only track one license date rather than several. Licenses are continued on a two-year cycle.

The change to the single producer license program also eliminated the burden of yearly license renewal. The DOI now grants perpetual licenses to producers. Once the Division grants a license, the license automatically continues every two years, provided the producer meets the fee and continuing education requirements. Nonrenewal by the DOI must follow proper due process procedures subsequently placing the burden on the DOI to request a hearing if the DOI acts not to renew a producer's license. Prior to 1995, the agent's or broker's licenses were terminated at the end of the license period and the burden of showing cause to be licensed fell on the agent and/or broker. Consequently, the Division could require the agent or broker to satisfy certain housecleaning activities before it issued a new license. Additionally, the agency was not compelled to renew a license, and the burden of filing for a hearing to have the DOI's decision reviewed fell on the agent or broker.

Although licensing of producers is administered by the DOI, an outside independent contractor, Assessment Systems Inc. (ASI), processes the application, administers the exam, and produces the license. An individual who wishes to be licensed must first complete a prelicensing course in the specific category of insurance. Courses must meet a minimum hours' requirement and cover specific information on a particular category of information. The Colorado statute requires prelicensing courses for property and casualty to be 50-hour courses while it requires life and health courses each to be 50 hours. There are approximately 30 prelicensing courses offered in the state.

Upon completion of the prelicensing course, individuals may then apply to sit for the exam. The DOI receives the names of the applicants from ASI and performs background checks on each applicant using the NAIC SAD database to ensure that the applicant has not been associated with illegal activities or received disciplinary action in another state. Upon passage of the exam and acceptance by the DOI, the applicant is issued a license for the area of insurance that they tested for.

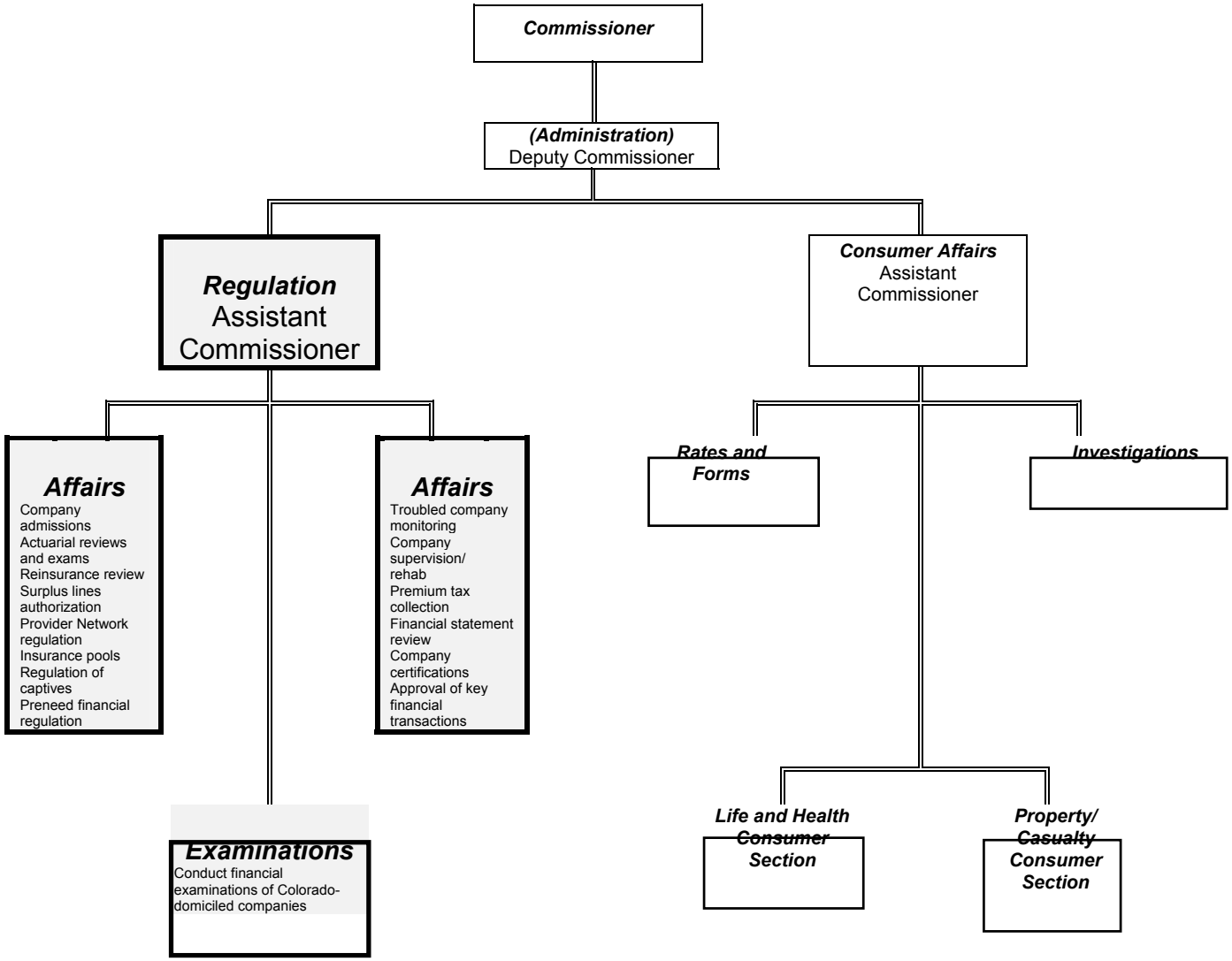
Since 1995, continuing education requirements have been required for all licensed producers. Producer licensing is composed of three FTE who handle the duties of administration of licensing, continuing education, and processing non-routine applications.

Legislation and Regulation

The DOI is affected by more proposed bills in the General Assembly than most other divisions within DORA. During the last session there were 79 bills introduced regarding various insurance concerns. The DOI tracks each bill introduced during the session and follows it through the Legislature. Additionally, when requested by a legislator, the Division provides background information for specific bills. When a bill becomes law by signature of the Governor or passage of the statutory time frame without a veto, the DOI implements whatever procedures are necessary to enact the statutory changes as efficiently as possible.

Additionally, several staff assist the commissioner in determining the regulatory direction of the Division of Insurance. Staff work with the industry and interest groups to identify regulatory issues and concerns and propose solutions to correct these problems.

B. FINANCIAL REGULATION



B. FINANCIAL REGULATION

Financial Regulation helps to ensure that companies operating an insurance business in Colorado are financially sound. Should an insurer become unsound, the policyholder loses the money paid in premiums plus the loss of payment for any claims. The policyholder must also look for replacement coverage, which may not be available or may be more expensive. As such, the most important public protection function performed by the Division of Insurance is to monitor the financial solvency of insurance companies. An insolvent company detrimentally affects all policyholders because they are unable to collect a claim from insolvent companies.

Before an insurance company can operate in the State of Colorado, it must first demonstrate it meets specific experience and financial standards. In an effort to describe the regulatory scheme within the DOI, it is best to identify the functions of financial regulation beginning with a company applying to the DOI for operation in the state and then to review the subsequent monitoring by the DOI once a company begins operation.

There are three specific sections within the Financial Regulation area. They are:

1. Corporate Affairs

2. Financial Examinations

3. Financial Affairs

Corporate Affairs performs actuarial reviews and determines if companies meet statutory requirements to operate in the state. Financial Examinations conducts examinations to determine the financial solvency of domiciled insurance companies. Financial Affairs focuses on financial analysis of companies, and it monitors financial solvency of domestic and foreign insurers on a continuous basis by reviewing financial statements. An additional function of Financial Affairs is to monitor troubled companies and to provide company supervision and rehabilitation under certain circumstances. The following chart illustrates which sections within the Division of Insurance become involved in the financial regulation of insurance companies.

(Financial Regulation Monitoring by DOI)

Application to Operate	Operations	Ongoing Analysis of Companies
|------Corporate Affairs-------|	|---Financial Examinations---|	
	|----------	----------Financial Affairs-------|

1. CORPORATE AFFAIRS SECTION

The Corporate Affairs Section is composed of ten FTE whose responsibilities include ensuring that companies wishing to operate in Colorado meet the statutory requirements. This section first reviews the type of business activity contemplated in order to determine if it falls within the domain of insurance regulation. The Division of Insurance relies heavily on Colorado Insurance Regulation 5-1-2, which distinguishes between insurance and warranty and service contracts. For example, some activities such as home warrantees, prepaid dental plans, and some auto service plans are considered insurance products.

If the activity meets the definition of insurance, Corporate Affairs then determines whether an insurance company meets the statutory and financial criteria to operate in Colorado. This includes an actuarial review to determine if the company meets the financial requirements outlined in the statutes and regulations to operate in the state. The DOI considers licensed insurance companies either domiciled companies or foreign companies. Domiciled companies are companies incorporated in the State of Colorado. Foreign companies are companies incorporated in another state. This distinction results in different reviews by the Division of Insurance, with a more thorough review performed on domiciled companies. Foreign companies generally have to provide additional experience documentation prior to being admitted to the state. Companies may also sell insurance in the state as authorized but unlicensed companies. This usually occurs with a company that sells only a single specialty insurance product, such as environmental liability or professional malpractice insurance not available through a licensed company. Authorized but unlicensed companies are still subject to financial review by the DOI Corporate Affairs Section.

Different lines of insurance have different statutory financial criteria. Additionally, the DOI reviews risk-based capital requirements with property, casualty, health, and life insurance company applicants when determining whether they have met financial thresholds to operate in the state.

The Corporate Affairs Section also reviews corporate changes, such as management changes, and corporate activities such as mergers. The purpose of this review is to ensure that the company is still able to meet its requirements after the change.

Additional duties within this section include financial examination of "non-traditional" insurance types. This includes self-insurance pools, preneeds, and captives (other than risk retention groups). Only domiciled insurance companies can provide nontraditional types of insurance within the state. (For a more detailed discussion of financial examinations, see page 34.)

Regional offices of foreign companies create employment opportunities, such as claims processing and adjusting, within the state. Companies operating a regional office in Colorado are eligible for a 1 percent premium tax rate. Corporate Affairs evaluates applications for regional office status and monitors the operations of the office once the state provides the status.

This unit also reviews preneed funeral companies. Individuals pay either a lump sum of money or installments over a period of time to a preneed plan. This entitles the purchaser to future funeral and/or burial services at a guaranteed price. This type of arrangement is a trust, an insurance product.

Corporate Affairs evaluates reinsurance arrangements between companies. Simply put, reinsurance is an activity whereby an insurance company transfers or assigns risk to another company. This frees up company reserves and allows it to sell more insurance. Insurance regulation requires strict standards for reinsurance to reduce the possibility that a reinsurance company does not have the financial ability to pay the assumed claims. Should this occur, the original company is responsible for claims payment.

Corporate Affairs also evaluates captive insurance companies. These are companies designed to write a specific, identified pool of insureds.

2. FINANCIAL EXAMINATIONS SECTION

Once a company receives approval from the Corporate Affairs Section and begins to operate in the state, the Financial Examinations Section will perform periodic examinations to determine compliance with state statutes. There are 15 FTE within the Financial Examinations Section: one chief examiner, 12 financial examiners, one electronic data processing (EDP) auditor, and one support staff. Most of the examiners are Colorado-licensed CPAs or have earned the designation of Accredited Financial Examiner (AFE) or Certified Financial Examiner (CFE) though the National Society of Financial Examiners. The number of financial examinations the section performs in a year ranges from the high teens to mid-twenties. The disparity in number results from the size of the companies being examined. The DOI provides companies notice prior to an examination. This notice is followed by a request for documents from the examiner in charge. Normally a financial examination requires two examiners from the state in addition to an actuary and an EDP auditor. The two examiners generally work continuously throughout the duration of the examination. The actuary's and EDP auditor's functions are generally focused on specific cooperate activities; the results of their work is incorporated into the examination report.

An examination consists of an audit of the insurance company's operations and financial records. DOI personnel will review financial statements, transactional information, management information, and claims information, as well as corporate charters and bylaws to ensure that the company is in compliance with all statutory requirements and fiduciary duties. Additionally, the examination will look at other factors in order to identify potential solvency problems such as whether the company is paying its claims. The examination is also important because it checks the accuracy of the annual statement which is relied upon by the DOI to provide yearly monitoring of the insurance company. DOI conducts financial examinations using procedures in the Colorado Examiners Handbook, which include all NAIC guidelines for conducting an examination.

Examination Conducted Every Three to Five Years

Colorado has the authority to examine any insurance company operating in the state. Financial examinations for traditional insurance companies occur every five years, while examinations for health maintenance organizations and the Colorado Uninsurable Health Plan (CUHIP) are required every three years. Through a coordinated NAIC process, (the zone examination system), Colorado performs financial examinations only on Colorado-domiciled companies. All other companies are reviewed by their domiciled state agency. Companies must supply copies of the examination results to the NAIC and all states where that insurance company is licensed.

Zone Calls

The NAIC issues a notice to all states when a state identifies that it will conduct a financial examination on its domiciled company. The NAIC divides the country into geographical zones. In situations where an insurance company has licenses in multiple states in multiple zones, or where a company has licenses in more than three states in any one zone, other states may participate in the examination. The NAIC coordinates examinations for large, multi-state companies. Referred to as the “zone call,” any state where that company operates may participate in the examination. When several states request participation, the NAIC Zone Secretary selects a state to represent the zone on the examination. The DOI rarely participates in examinations of companies not domiciled in Colorado. In the last five years, Colorado has participated in three zone examinations.

Types of Companies Examined

Insurance companies examined by the DOI fall into two distinct categories: "traditional" and "nontraditional." "Traditional" insurance companies make up the majority of the insurance industry in Colorado and include such company types as life, casualty, and property. Below is a list of types of "traditional" companies and their number operating in Colorado.

Company Type	FY 95-96
Life	17
Multiple Line	14
Casualty	7
HMO	15
County Mutual	4
Nonprofit	5
Fraternal	2
Title	3
Captive-Risk Retention Companies	3
Other (CCIA and CUHIP)	2
TOTAL	72

Self-insurance pools, preneeds, and captives insurers (other than risk retention groups) make up "nontraditional "insurance companies. The Corporate Affairs Section examines these companies. As directed by statute, the Division reviews self-insurance pools every year, while it reviews captives on a risk-based approach. The Division reviews preneed insurance companies on an as-needed basis.

Selection of Companies

Each year the DOI selects a number of domestic companies to be examined based on preselected factors.[4]

The DOI documents the rationale used to select insurance companies identified for financial examinations. For example, the DOI may not select a company identified by the NAIC as being a high priority for examination because they are already operating under a state-appointed outside supervisor who monitors the company's financial status on a continual basis. In another situation, the DOI may not select a certain company but prefer to wait and conduct simultaneous examinations with other companies that offer the same line of insurance with similarly identified concerns about reserves, unearned premium, and premium accounting. This simultaneous examination facilitates the identification and consistent treatment of issues unique to these companies.

Costs of the examination for domestic companies headquartered in the state are covered by the premium tax imposed on all insurance companies licensed in the state. (For an explanation of the Premium Tax see 42.) If the domestic insurance company is not headquartered in the state or does not pay premium taxes (e.g., HMOs, nonprofits, fraternal), the insurance company must reimburse DOI for the financial exam. There are approximately 20 companies domiciled in Colorado but not headquartered in the state. When DOI participates in the financial examination of a foreign insurer operating in the State of Colorado, the company must reimburse DOI for the cost of the examination.

[4]For example, in 1996, the DOI used the following factors:

A. Any company identified by the DOI as high-priority. Companies identified by the NAIC early warning system and the NAIC Examiner Team as needing immediate regulatory attention and concurred with by the DOI.
B. Companies selected based on negative reports from the Financial Analysis and Actuarial Sections as well as consideration of each entity's financial condition, risk-based capital, and surplus, results from prior examinations, and changes in operations and/or management.
C. Examinations required by statute.
D. The period of time since the last examination was three years.

The financial examination team identifies operational and financial issues in a report. The DOI issues a draft of the report to the insurance company to allow the company to make written comments with respect to any issues identified in the report. After reviewing written comments and reviewing the report, the Commissioner issues an order which either:

- Adopts the report as filed or with specific modifications. If the report identifies statutory noncompliance, the company is ordered to take corrective action to cure the violation;

- Rejects the report and directs the examiners to reopen the examination for the purpose of obtaining additional information and refile the report; or

- Calls for an investigatory hearing for purposes of obtaining additional data or information.

Commissioner orders are considered final agency decisions and are served upon the company along with the final report. A review of the decision may be sought by the company in Denver District Court. The reports become public records after 30 days of the issuance of the Commissioner's order. Within 60 days after the issuance of the order, the company's directors are required to file affidavits stating they have received a copy of the adopted report and related order.

The DOI has no punitive authority to fine a company that has been in violation of a statute, nor may it formally require that corrective action be taken by a specific date. The DOI's leverage lies with its ability to issue an order placing the company under supervision or receivership, depending on the severity of noncompliance.

Corrective Action

If the examination reveals a financial condition which could jeopardize policyholders, the Commissioner has several regulatory options. The Commissioner may order closer monitoring of the company, including increasing the frequency of either financial reports or examinations. The Commissioner could also place the company under supervision, in which case the Commissioner would select an outside insurance or financial executive to serve as the chief executive officer under a supervision order. In extreme situations, the Commissioner can place the company into receivership until it either recovers or is liquidated. In each of these situations, oversight for the company is the responsibility of the Financial Affairs Section of the DOI.

3. FINANCIAL AFFAIRS SECTION

The Financial Affairs Section is the last of the three sections that monitors the financial soundness of the insurer. This section provides continuous monitoring of the financial condition and regulatory compliance of companies. Additionally, this section collects the premium tax imposed on all insurance companies that operate in the state. Financial Affairs separates their responsibilities into three functions: 1) financial analysis, 2) trouble company monitoring, and 3) premium tax collection. The Financial Affairs Section has seven employees in the following positions: one supervisor, three financial analysts, one troubled company monitoring analyst, one premium tax analyst, and one administrative assistant.

Financial Analysis

Every insurer in the country must file an annual statement with the NAIC and with every state where they are licensed. Self-insured entities must file independently audited reports in a similar manner with state regulators. The comprehensive annual statement details financial information about the company including assets, liabilities, and cash flow. The annual statement also provides underwriting and investment summaries of losses and gains. The financial examination checks the accuracy of past annual statements and is conducted every three to five years. The annual statement provides information in a number of predesigned informational tables. Procedural requirements in producing the annual statement are necessary for uniformity. Colorado, like all states, uses the annual statement to monitor the financial strength of each company by analyzing assets, investments, liabilities, capital and other financial information, and comparing various ratios reported in the statement. For example, the Division will compare gross premium in the state with surplus the company has in reserve. The Division will also compare certain ratios with NAIC standards. The NAIC has an Insurance Regulatory Evaluation System (IRES) which compares 11 ratios in the property and casualty lines and 12 ratios in the life and health lines. The NAIC places all companies on a priority list who have several ratios that are outside of normal ranges. This list is then distributed to all states alerting them to those companies that may have solvency problems.

Another tool used by the DOI to monitor insurance companies is the database called SITE (State Interface Technology Enhancement). The NAIC operates and maintains the database which contains all insurance companies' annual statements on-line. SITE allows the insurance regulator to identify trends in the market and compare with companies in its own state.

Through these and other tools, Financial Affairs performs financial analysis to identify troubled companies. The Financial Affairs Section has three analysts who perform reviews on approximately 70 domestic companies and 1600 foreign companies. Additionally, as resources permit, temporary clerical help is contracted for to assist processing the numerous insurance company annual premium tax filings.

Troubled Company Monitoring

Once a company has been identified as a "troubled company," the DOI may take a number of actions to protect the public. However, actions taken against insurers by the Division vary depending upon whether the company is foreign or domestic. The Division has more options with a domestic company. Depending upon the severity of the solvency problem, the Division may prohibit the domestic insurer from selling new policies in the state. This prohibition occurs either through an informal agreement called a "no sale" agreement or through a more formal suspension of their license. Other actions are designed to rehabilitate the company. Some rehabilitation activities closely monitor the insurance company, and the DOI may require special reporting requirements. The Financial Affairs Section monitors all reports to ensure that the insurance company does not become incapable of meeting its financial obligations. Other rehabilitative actions may require supervision of the company by an outside person until it becomes financially sound. If the company is severely financially handicapped, the DOI may place the insurance company into receivership. Should this action occur, the Division takes control of the company in an attempt to rehabilitate the company. If the company cannot be rehabilitated, the company's books of business may be sold or its assets may be liquidated.

Regulatory actions taken against insurers by the Division vary depending upon severity of the problem and whether the company is domestic or foreign. While certain regulatory remedies tend to be applied depending on whether an insurer is domestic or foreign, all remedies under law apply to all insurers doing business in Colorado.

Regulatory actions taken upon domestic insurers generally constitute special monitoring activities, prohibiting a domestic insurer from selling new business, placing the insurer under a DOI order of supervision, or placing the insurer into receivership through court proceedings for rehabilitation or liquidation.

Regulatory actions taken upon foreign insurers constitute special monitoring activities, prohibiting the insurer from selling new business through an informal "no sales" agreement, or an order of suspension. When a foreign insurer is placed into receivership by the domiciliary state, the Colorado DOI will issue an order of suspension upon the insurer.

Last year, Financial Affairs monitored two domestic troubled companies and had one insurer under supervision. During that same period, they suspended the licenses of three insurers and placed four insurers under no sales.

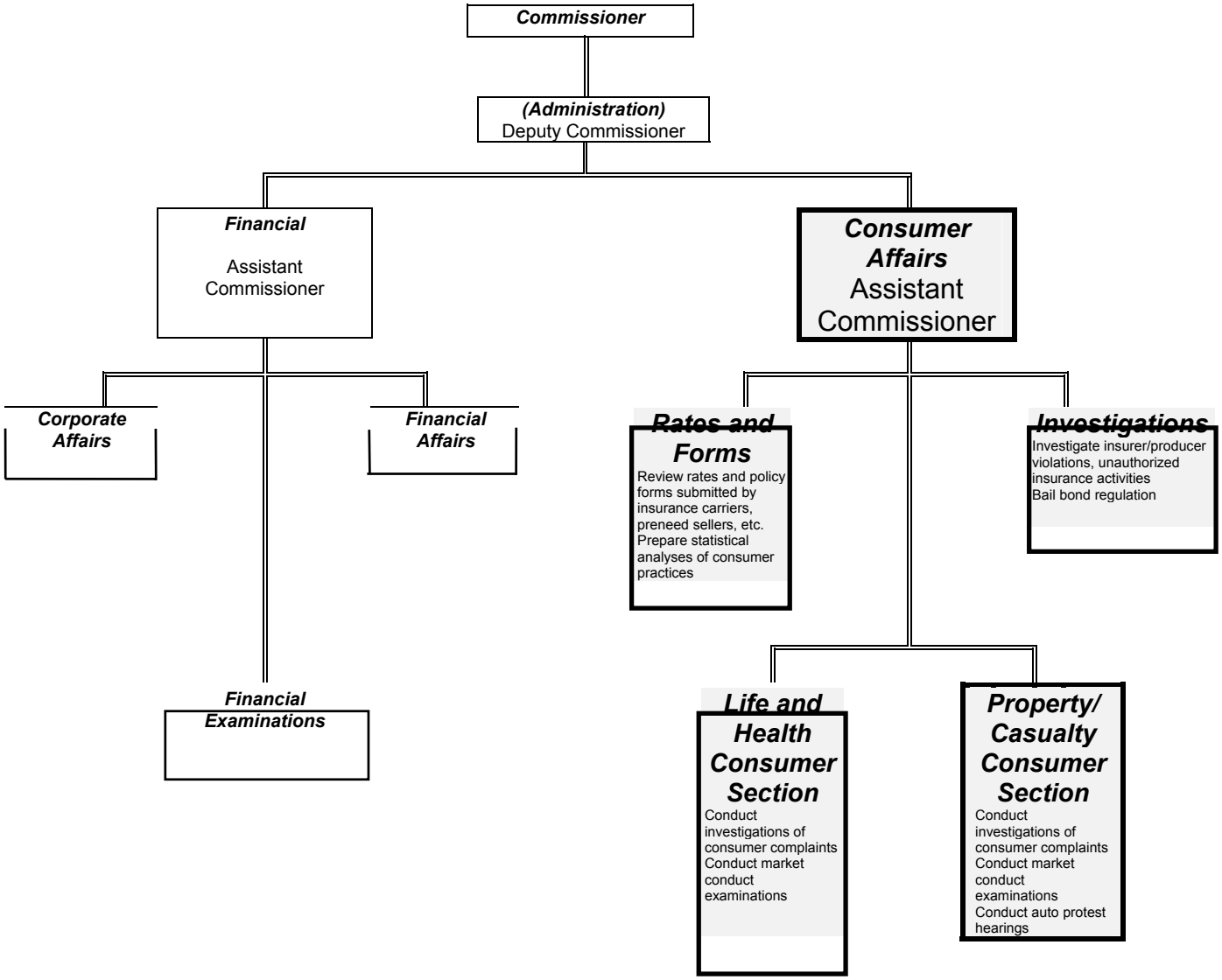
Premium Tax

The State of Colorado places a 2.2 percent tax on all in-state insurance premiums collected by authorized insurance companies, except for regional home offices, which receive a 1 percent tax rate. Computation of the premium tax is based on the total insurance premium volume sold in the state. Last year, Colorado collected $107 million in premium tax.

Additionally, Colorado has a retaliatory tax. This requires an insurance company to pay the state the higher of the tax between the domiciled state's and Colorado's. Every state has this provision, and it effectively stabilizes tax rates for companies nationally.

The Financial Affairs Section has one FTE who collects and monitors the premium tax. Additionally, the Division hires temporary employees to assist with reviewing premium tax payments and returns as resources permit.

C. CONSUMER AFFAIRS



C. CONSUMER AFFAIRS

An Assistant Commissioner of the DOI manages the Consumer Affairs Section. It is the assistant's responsibility to respond to consumer complaints and problems with market practices within the insurance industry and to take corrective action to protect the public from harm. The Consumer Affairs Section comprises four areas. They are:

1. Review of insurance rates and forms;

2. Investigations against insurance producers and unauthorized companies;

3. Consumer issues related to the life and health insurance industry; and

4. Consumer issues related to the property and casualty insurance industry.

Consumer Affairs currently consists of 34 FTE, most of whom resolve consumer complaints. Last year the Division received over 7000 written inquiries, complaints and protests.

Consumer Affairs Personnel Breakdown

Rates and Forms				
	Position	**FTE**		
	Review Analyst	3		
	Statistician	1		
	Administrative Assistants	2		
	Supervisor	**1**	**Total**	**7**
Investigations				
	Position	**FTE**		
	Chief	1		
	Investigators	3	**Total**	**4**
Life and Health				
	Position	**FTE**		
	Analyst	5		
	Assistant Analyst	3		
	Market Conduct Examiner	1		
	Supervisor	**1**	**Total**	**10**
Property and Casualty Section				
	Position	**FTE**		
	Analyst	6		
	Assistant Analyst	3		
	Market Conduct Examiner	1		
	Supervisor	**1**	**Total**	**11**
Other				
	Position	**FTE**		
	Office Manager	1		
	Regulatory Affairs/Policy P&C	1	**Total**	**2**
			GRAND TOTAL	**34**

1. RATES AND FORMS

The Rates and Forms Section within Consumer Affairs is responsible for reviewing filings of premium rate changes (Rates) and new insurance products (Forms). This section is composed of seven FTE, staffed as five analysts and two administrative assistants. Four of the analysts are responsible for reviewing rate changes and policy forms submitted by insurance carriers to the state. The fifth analyst is a statistician who maintains various DOI databases related to the enforcement of the insurance industry and runs analyses from the data. The two administrative assistants provide clerical support and process all rate filings and policy forms submitted by the industry. Processing of filings includes a paper audit to ensure that all documentation is present.

There are two types of rate and form filings required in the Colorado insurance statutes. The type of insurance offered by the company dictates the method required for filing with the DOI. The prevalent filing method required by Colorado is the File and Use System. This includes rate determinations for most property and casualty and life and health insurance lines. The second method is the Prior Approval System. This system applies to lines of insurance which are not considered to be competitive, or are specifically identified in statute. Both systems require varying degrees of regulatory oversight by the DOI.

A. File and Use

Approximately half of the states regulate insurance rates and forms through a file and use system, where changes in premium rates to the consumer need only be filed with the DOI before the company can use the rate. This system relies primarily on the free market to set premium rates. Filed rate changes must include supporting documentation. If the filing for a rate or form does not provide the required supporting documentation, the Division returns the information, and the insurance company may not use the filed rate or form.

Rate and Rule Filings

Last year the Division processed 7000 property and casualty rate and rule filings and approximately 2000 health insurance rate and rule filings.

Due to the volume of filings and the lack of resources, the DOI performs a review of approximately 14 percent of property and casualty and 91 percent of health rates processed. Last year, the DOI reviewed roughly 1300 health and 800 property and casualty rates and rule changes filings. Rate filings are examined for claims payouts, trends, investment income, expenses and experience. If the Division determines that the filed rate is excessive, inadequate, or unfairly discriminatory, it will take administrative action to disallow the rate filing.

The Division uses many criteria to determine when a rate filing will be reviewed by an analyst. Some of these criteria include automatic triggering guidelines (e.g., rate increases greater than a target percentage, competitiveness of the market.)

The statutes also contain many specific authorizations for examination and authority to examine certain kinds of insurers, (i.e., HMOs §10-16-314, C.R.S.; Nonprofit insurance companies §10-16-416, C.R.S.; Colorado Compensation Authority §8-45-121(4), C.R.S.; Colorado Uninsurable Health Insurance Plan §10-8-510(2), C.R.S.; and Prepaid Dental Plans §10-1-200, C.R.S.)

Policy Forms Filings (New Product Filings)

The Rates and Forms Section also reviews and approves forms or policies sold in Colorado. Newly licensed companies submit the actual policy along with underwriting criteria to the DOI for approval prior to selling any insurance products in Colorado. The Division reviews all policies to ensure they include mandatory coverages.

Existing companies self-certify new insurance products. This involves a corporate officer completing a checklist and affidavit stating the policy complies with Colorado law. The Rates and Forms section routinely reviews new products in high-profile lines, such as personal passenger auto, and small group and major medical, because of high consumer impact. Eighty percent of the auto insurance market has its rates reviewed by the DOI. Other lines are generally reviewed only when a consumer files a complaint or as part of a market conduct examination.

Last year the section processed approximately 3000 health policy forms and 2000 property and casualty policy forms. Of that number, the Division reviewed roughly 300 health policy forms and 100 property and casualty forms.

B. Prior Approval

Under a prior approval system of regulating insurance rates and forms, the state must approve a rate prior to the insurance company using it. This system requires a tremendous number of resources as every filing must be reviewed. At the same time, it is less likely that insurance companies will charge excessive rates to the consumer. Approximately half of the states use this system as their primary regulatory rate and form filing process. Colorado requires prior approval on some smaller insurance lines where there is little competition in the market for the product. Colorado requires prior approval rates for the following insurance lines:

- Workers' Compensation
- Assigned Risk Automobile
- Medical Malpractice Joint Underwriting Association
- Credit Insurance
- Medicare Supplement

C. Enforcement

If problems are found with an insurance product, Rates and Forms can review claims and require the insurance company to pay interest on claims improperly denied. The Division can also require companies to "search for claims," meaning to request information from policyholders on similar claims that were not submitted or had been improperly denied.

The unit produces a newsletter and conducts industry seminars to alert insurance companies about problems with interpretations of mandated benefits and improperly denied claims. The Division regularly produces consumer-oriented publications that provide rate and coverage comparisons between companies in certain product lines, such as homeowners and personal passenger auto insurance. The Rates and Forms Section also compiles and publishes information on complaint ratios on insurance companies.

2. INVESTIGATIONS

1. Investigation of all complaints against property/casualty, and life/health producers (agents and brokers),
2. Investigation of complaints against bail bond agents, and
3. Investigation of unauthorized insurance sales.

The Investigations Section is responsible for reviewing all complaints against insurance producers and unauthorized companies. Their investigations may be categorized into three areas of responsibility.

The Investigations Section is composed of four FTE of which three are investigators and one is a supervisor. Although responsible for all types of complaints, familiarity with certain insurance laws allows investigators to specialize in certain complaint areas. For example, one investigator handles all complaints against bail bond agents. A second investigator is more familiar with property and casualty problems, while another is specializes in life and health issues.

Producer Complaint Investigations

Upon receipt of a complaint, the Division enters it into the state's computerized complaint system. If the complaint is about a producer, the section will investigate the complaint, collect documentation, and take corrective action if necessary. Producer investigations usually involve the agent's fiduciary responsibility to the policyholder. Such actions may include collecting premiums and not remitting the funds to the insurance company or misrepresenting the scope of the insurance policy or the premium amount to the policyholder.

Bail Bond Agent Complaint Investigations

The Division of Insurance is responsible for the licensing and regulation of professional bail bond agents and companies. As of 1995, there were 320 licensed agents in the state. The Investigations Section handles all complaints against bail bond agents. In 1995, the DOI received 389 complaints against bail bond agents. Complaints are addressed in the same manner as producer complaint investigations. Bail bond investigations usually involve agents' failure to obey court-ordered forfeitures. Other areas of complaint investigations by the Division include failure to maintain proper records or falsification of records, as well as theft of premiums and/or collateral.

Insurance Fraud Investigations

Unauthorized insurance companies that operate scams have a large potential impact on Colorado consumers. Often these scams are quite elaborate and involve companies which are headquartered in the Caribbean. An individual will create a company with phony assets. This is accomplished by selling stock to other accomplices who inflate the value of the company through a paper transfer. An unethical accountant (CPA) verifies that the assets are sound. The president or associates then approach independent insurance producers within the state and present the company as a legitimate entity (with proper papers) wishing to sell insurance. The producer, failing to make a due diligence check, sells insurance for the company. The company will pay a few small claims but then disappear with all the premiums collected. The DOI only becomes aware of these companies when they receive a complaint about unpaid claims. By then, the damage is already done.

Most victims of these scams are small businesses (usually involving Workers' Compensation insurance), high-risk auto, environmental liability, and professional liability (malpractice). These lines usually have high premiums and people are willing to take chances with an unknown company for substantial savings.

A producer performing the proper due diligence check required by statute can prevent scams like these. They only need to contact the DOI to determine if the company is licensed or authorized to sell insurance in the state.

Another fraudulent action seen by the DOI is insurance products that are represented as exempt from state insurance regulation under the Employee Retirement Insurance Security Act (ERISA) or the North American Free Trade Agreement (NAFTA). The “insurance” company will misrepresent a local civil law firm’s legal opinion regarding the exemption of that insurance type. The company will use this misrepresentation to sell their product to producers. Examples of these products are single employer benefit plans and multiple employee welfare associations. They also sell products to small business owners as 24-hour coverage in place of Workers’ Compensation.

Insurance fraud experts estimate that insurance consumers lose millions of dollars each year from scams like these. When the DOI discovers a scam, they seldom pursue actions against the producer but rather plea bargain with the producer to testify against the company. Colorado performs one to two investigations per month on unauthorized companies operating in the state.

Insurance fraud is difficult to prosecute because these issues can be quite complex, and there is a steep learning curve to understand these cases. Cases may take years to complete; consequently, these cases require many resources, preventing many state and local prosecutors from prosecuting violators.

The Investigation Section is also responsible for conducting background checks on applicants for a producer license. While the Single Producer Act privatized most of this process, the DOI still retains the responsibility for ensuring that individuals with criminal records or disciplinary actions from other state insurance authorities are prevented from being licensed in Colorado.

3. LIFE AND HEALTH SECTION

Like the Property and Casualty Section, the Life and Health Section handles complaints about companies, responds to requests for information, and conducts market conduct examinations. The only difference in responsibilities from the Property and Casualty Section is that there are no protest hearings in the Life and Health Section. The section currently has ten staff which are identified below:

Complaints

Life and Health predominately receives complaints about health insurance. Complaints range anywhere from claims not being paid or delayed to mandated benefits not offered or excluded. Another area common in health complaints is the quality of care complaint. These complaints arise out of HMO's providing what the consumer believes to be inadequate or inappropriate care . Although the DOI does not have jurisdiction over quality of care issues, §10-16-409, C.R.S., requires the HMO to have a complaint procedure approved by the Commissioner. Many insurance plans with managed care components have voluntarily instituted similar grievance procedures. The Colorado Department of Public Health and Environment has some regulatory responsibility over quality of care issues in HMOs.

The section also receives, with increasing frequency, complaints against life insurance companies. These complaints center around misrepresentations of the producer (agent) when selling the policy. Often the complaints revolve around the continuation of premium payments. A producer allegedly sells a life insurance policy and states that the premium payment will only be for a specific number of years. Years later, because interest projections used in the sale were overstated, policyholders are informed that they must resume premium payments. Policyholders have limited options. They may either enter into a class action suit and stay apprised with the suit, individually sue the life insurance company, or go through the DOI.

Market Conduct Examinations

This is the first year that the section will conduct market conduct examinations, and they expect to conduct five exams in the current year. The criteria used to identify companies for the examination include:

- Complaint ratio
- Review of marketing materials
- Review of policy materials
- Complaint investigation results

In addition to the market conduct examination, the section may conduct desk examinations at any time. This examination is quicker and investigates one specific activity of insurance companies. The analyst requests information about specific policy provisions from the company and the company uses internal resources to provide the information. An example of this desk examination is the DOI's identification of companies not applying maternity benefits correctly to policyholders. The DOI received many complaints revealing claims denied for incorrect reasons. As a result, the Life and Health Section checked other companies to determine their compliance statutory requirements.

Consumer Affairs Complaint Information

Health Complaints Specific Complaints (not inclusive)			
Year	Health Co.	Agent	Self-Ins.
1992	1574	51	69
1993	1237	35	52
1994	1056	20	48
1995	1009	9	13

Life Complaints Specific Complaints (not inclusive)		
Year	Life Co.	Agent
1992	315	90
1993	272	53
1994	304	64
1995	314	52

Property & Casualty Specific Complaints (not inclusive)			
Year	Property & Casualty Company	Agent	Self-Insured
1992	5554	1810	18
1993	4498	517	26
1994	4221	169	19
1995	4337	113	17

4. PROPERTY AND CASUALTY SECTION

Responsibilities of the property and casualty area of the Consumer Affairs Section fall into three specific areas: resolving consumer complaints, responding to consumer requests for information, and conducting market conduct examinations. There are 11 employees/FTE within the property and casualty section. Six analysts and three assistant analysts handle all complaints from consumers against property and casualty insurance companies, answer telephone calls, handle protest hearings, and provide enforcement activities (e.g., negotiate corrective actions). In Fiscal Year 1995, the Division handled thousands of inquiries related to property and casualty issues. Additionally, the staff received over 4800 written complaints, resolving most of them within the year.

Assistant analysts are paraprofessionals. They are usually able to resolve the less complex or controversial complaints, and answer 60-70 percent of the telephone inquiries. Each assistant analyst must answer telephones 4 1/2 hours each day. They also open and close files and maintain about 20-30 active files.

There is one market conduct examiner who performs examinations and oversees contract market examiners.

Consumer Inquiries and Complaints

The Division receives thousands of telephone insurance inquiries a year. Last year alone, the DOI received well over 60,000 telephone inquiries related to consumer questions and concerns about insurance issues. The Division staff will attempt to resolve the issue immediately and are often successful. If the analyst cannot resolve the issue immediately, the analyst will suggest that the consumer file a written complaint. The Division requests that all complaints be put in writing, which provides the DOI with documentation of the complaint. Consumer complaints are received by the DOI in person, by mail, or by fax. The DOI will first determine whether the consumer may be able to resolve the dispute on his or her own before getting the DOI involved. Once the Division receives a complaint, it is routed to an analyst for review. The analyst will send a letter to the company and the insured requesting information regarding the complaint. The company has 20 days in which to respond to the DOI. The analyst will review the information and talk with the insured and the company. Upon analysis, the Division will take appropriate action. After the issue is resolved, the DOI will send out follow-up letters to track whether the process worked well. Numbers for complaints received are reprinted in every DOI quarterly report.

No-Fault Protest Hearings

Almost half of the complaints received by the Property and Casualty Section regard no-fault auto insurance. Because of the high rate of complaints in this area, the Legislature established a no-fault protest hearing procedure under §10-4-720, C.R.S. Consumers may request a "no-fault" protest hearing when an insurer takes certain actions against the consumer's automobile insurance. These actions include cancellation, nonrenewal, increase in premium, or reduction in coverage, as well as nonpayment or slow payment of claims. The DOI has one analyst working full-time as a Hearing Officer in protest cases. On the basis of the protest, the Hearing Officer may:

- Dismiss the protest because the insured's action is allowed,
- Grant the protest and instruct the company to rescind its notice of intended action because the notice on its face does not meet the statutory parameters,
- Schedule a hearing to take testimony and evidence after which a written determination is made and mailed to the parties.

In 1995, the DOI received over 2300 no-fault protest hearing requests. Division personnel resolved almost 1800 of these complaints through a review of the documentation prior to a hearing. Usually the initial determination was in favor of the insurer. This informal analysis by the Division provides an excellent educational device to consumers while also assisting companies by quickly resolving potential disputes. Of the number of hearings held, 434, or 78 percent of the rulings were in favor of the insured. The high number of rulings in favor of the consumer indicates that this process is a very strong consumer tool saving the public thousands of dollars from unwarranted premium increases by the insurance company.

# of Protest Requests	***Resolved Prior to a Hearing***			***Hearings Held***		
2329	**Total**	In Company Favor	In Consumer Favor	**Total**	In Company Favor	In Consumer Favor
	1774	1319 - 74%	455 - 26%	**555**	121 - 22%	434 - 78%

Other Complaint Areas

The Property and Casualty Section also receives a large number of complaints relating to homeowner's insurance. These complaints involve similar actions as those in personal passenger auto, such as cancellation, nonrenewal, increase in premium, reduction in coverage, as well as nonpayment or slow payment of claims. Additionally, the Division resolves many other complaints related to auto insurance other than those covered by the protest hearing. These complaints primarily include coverage issues, nonpayment of claims, or late payment claims. Commercial insurance lines and title insurance companies receive fewer complaints.

Market Conduct Examinations

The market conduct examination reviews insurance company compliance with Colorado statutes and regulations concerning business practices of an insurer with applicants, policyholders, and claimants. The market conduct examination focuses on the business patterns and practices of an insurer in the areas of sales and advertising, underwriting, rating, and claims. Market conduct examinations are triggered through a variety of means. Most often they arise from:

- The DOI's review of rate and form filings,
- Consumer complaints and analysis of those complaints,
- Information provided from other states' experiences including market conduct examinations of companies also doing business in Colorado.

Traditionally market conduct examinations have been comprehensive examinations involving all areas of a company's business practices. The Division rarely if ever performs this type of examination. Rather, the examination by the DOI targets a specific area of concern about a company's practices. Through communications with other sections within the DOI and complaints received about a company, the DOI is able to identify specific areas of concern within a company. Additionally, the DOI will also look at the market share the company represents in the state and total number of complaints as other factors considered when identifying a company for a market conduct examination.

The Commissioner is given specific authority to examine insurance companies at any time under §§10-1-203 and 204, C.R.S. An examination is defined in §10-1-202(3), C.R.S., as either a market conduct or a financial examination.

RECOMMENDATIONS

Recommendation #1: Continue the Division of Insurance

Due to the complexity of insurance and the adequate ability of the Division of Insurance to protect insurance buyers and policyholders, this Sunset Review recommends the continuation of state regulation of the insurance industry.

Summary: For over one hundred years, the regulation of insurance has been conducted by the state. Through a coordinated effort with other states, Colorado has been able to meet the challenges of this ever-changing industry by adequately ensuring that the possibility of insolvencies are minimized while at the same time protecting state consumers. Although federal regulation of the industry theoretically could provide better and more uniform oversight of the industry, it would also reduce regulatory flexibility and remove Colorado's control of the insurers within its boundaries. Consequently, this review recommends the continuation of the Division of Insurance.

Discussion: The central questions which a sunset review seeks to answer are whether regulation by the agency is necessary to protect the public's health, safety and welfare, whether the conditions which led to the initial regulation have changed, and whether other conditions have arisen which would warrant more, less, or the same degree of regulation.

The regulation of insurance requires a thorough knowledge of complex issues related to the insurance industry, its practices, and its effects on the general public. Currently, the DOI provides this service. To perform these functions, the DOI requires adequate staff and resources to ensure that insurance companies are operating in a financially sound manner so that catastrophic insolvencies are prevented. Additionally, the Division uses other resources to ensure that insurance producers and companies offer services that are honest and without misrepresentation, and that comply with state statutory and regulatory requirements.

Since 1982, the DOI has been the subject of two sunset reviews which determined that the DOI should continue. The first review concluded that state regulation was necessary to “protect insurance buyer's and policyholder's vast investments.” This statement, made over a decade ago, is even more critical today. Since that time, the insurance industry has grown in Colorado from a $2.3 billion industry in 1982 to just over $13 billion in 1996. This six-fold increase in growth rests squarely on the shoulders of the Colorado public. Any failure in the insurance market will burden the Colorado consumers and policyholders.

A second sunset review conducted in 1991 concurred that regulation of the insurance industry is important and should be continued. This review followed an exhaustive and highly critical State Auditor's Performance Audit conducted in 1989. One of the audit's primary findings was that the Division's consumer inquiries and complaint processes were lacking. Consequently, the Division was reorganized to better address consumer issues against insurance carriers and producers.

The mission by which the Division of Insurance operates is simple and clear:

Our Mission is Consumer Protection

This mission statement articulates the basic finding shared by all reports. That is, the regulation of insurance is necessary to protect the public. If regulation is necessary, then the issue shifts to who should perform those regulatory duties.

Federal Regulation of Insurance

Over the last several years, government and industry have reviewed the merits of federal regulation of insurance. This issue continues to emerge as an alternative to the current state system. Under the McCarran Ferguson Act of 1945, the federal government is authorized to preempt the states from regulating insurance, but that authority is held in abeyance as long as states assume this regulatory responsibility. Since the 1980s, there has been considerable debate challenging various aspects of the McCarran Ferguson Act. Reacting to the high number of insurance insolvencies in the country, Congress has questioned whether a federal agency would provide a stronger regulatory program than the states. Advocates of federal regulation believe that a federal program would better protect the public through stricter regulations. Under the current state system, a consensus of states at the NAIC is required to develop model state legislation. Each state, as part of the accreditation process, adopts the language providing uniformity throughout the country. (See page 21 for a more detailed description of the NAIC.) The NAIC has limited authority by way of accreditation to enforce compliance with model legislation. Rather, it must rely on voluntary consensus by the states. Often model legislation is weakened in order to achieve such consensus. Proponents of a federal regulatory scheme argue that a federal program would eliminate such compromises. A federal agency could mandate stronger legislation to the states.

Proponents of federalism in the insurance arena believe that the insurance industry has become so large that states do not have adequate resources to ensure a sound insurance industry. If the federal government regulated insurance, there would be more resources to conduct national enforcement tracking and to perform regulatory reviews. The federal government would handle complaints against companies and producers as well as conduct financial exams and market conduct reviews. Most importantly, insurance solvency and market conduct examinations would be consistent throughout the country rather than relying upon each domiciled state (with varying resources) to ensure that companies were operating correctly.

Finally, federal regulation of insurance would benefit those in the industry by reducing duplication of licenses for agents who write insurance in more than one state. Customers often request property and casualty insurance agents to write insurance for newly acquired property in another state. This requires that the insurance agent be licensed in the state where that new property will be insured. Under a federal licensing program, the agent would need only one license rather than multiple licenses.

State Regulation of Insurance

Although federal regulation would reduce the responsibilities of Colorado within the insurance industry, it would also reduce the decision-making capabilities available to the state. Regulation is most efficient when conducted at the closest available level to the public. The closer that level, the more attentive the regulatory response is to the public's needs. State authority can more easily identify and address insurance issues particular to the State of Colorado and its citizens than can a federal bureaucracy. States can act more quickly and provide necessary legislation to correct problems unique to the state. A federal agency makes decisions on a national level. Consequently, it may be reluctant or slower to propose changes which address problems in only a few states.

Under the current system, states are able to adapt more quickly to the needs of the public. State regulation becomes a breeding ground of new regulatory ideas which when successful are copied in other states. A federal bureaucracy would not have this luxury.

Currently, there is no federal insurance regulatory body. States perform all regulation. If Colorado chose to give the regulatory responsibilities to the federal government, there would continue to be 49 other states independently regulating insurance. Ultimately, the benefits of federal regulation only occur if all states are under the federal umbrella.

The state has regulated insurance in Colorado since 1883 and has performed an admirable job of protecting the public. Although federal regulation of the insurance industry provides many compelling arguments, especially the adequate appropriation of funds and resources by the government to provide effective oversight and enforcement, the elimination of Colorado's Division of Insurance would create more burdens on the public than benefits received. For these reasons, this Sunset Review recommends the continuation of the Division of Insurance.

Recommendation #2: Give The Division Two Additional Attorneys Within the Attorney General's Office

The Division should be given two additional attorneys to assist in litigation and enforcement actions.

Summary: The Division receives over 60,000 inquiries and approximately 7000 formal consumer complaints against insurers and their agents each year. A comparison to other states reveals that Colorado receives more complaints compared to premium written than other states in the same geographical location or premium size. Additionally, Colorado's enforcement record against insurers and agents is weaker than those states. Much of the reason for the Division's weak record is the lack of available legal resources. Colorado devotes two attorneys to handling all actions against insurance issues. A comparison of surrounding states reveals that Colorado should have at least twice that number. For example, Wyoming, which writes approximately one-tenth of the amount of premium as Colorado devotes two attorneys to their enforcement needs. Additional Assistant Attorney Generals would be used to assist in the following areas:

- Consumer disputes
- Fraudulent sales of insurance
- Market conduct examinations
- Agent misconduct
- Insurer misconduct

Discussion: The role of any regulatory program is to provide oversight of a certain occupation or industry which results in a protected public. An important element in achieving this goal is the use of proactive measures to identify problems before public harm has occurred. Proactive measures are also useful in educating both the regulated community and the public of the rights and obligations each has to the other. When education is comprehensive, the consequences result in fewer disciplinary and enforcement actions and ultimately reduce the number of consumer complaints against the regulated community. Ideally, a regulatory agency's concentration on education and other proactive measures results in two important consequences: 1) a higher awareness and greater adherence to the laws and rules, and 2) an educated public which has the knowledge to ask informed questions when selecting a particular and appropriate service.

An equally necessary regulatory component in public protection is an agency's ability to take appropriate enforcement actions against those who violate the laws and rules. When proactive measures fail to keep the regulated community from operating correctly, varying degrees of state action must be taken to ensure compliance. Enforcement actions have a two-fold effect. First, they punish the illegal activity, and second, they act as a deterrent for future misconduct by the company and the rest of the regulated community. However, without an enforcement presence, there is no deterrent factor and the public must rely only upon the good will of the regulated community.

Failure of either of these components may manifest itself in public dissatisfaction with the regulated community and/or the agency while resulting in a more reactive role for the agency. Consequently, the agency must direct more of its resources to addressing complaints that could have been prevented through proactive measures.

As described in the first part of the report, the responsibilities within the Division are as far reaching as the regulation of the industry is expansive. On the consumer side, the DOI must investigate everything from fraudulent insurance claims to inappropriate marketing techniques. Over the last two years, the Division has attempted to strengthen its regulatory role. Not granted additional resources by the Legislature for in-house staff to conduct market conduct examinations, the DOI has spent the last year in an effort to operate with contract staff. Additionally, consumer response to the Division's handling of complaints has been positive. On the financial side, the Division's main regulatory function is to prevent insolvencies, and over the last five years, Colorado-domiciled companies have suffered no insolvencies. Overwhelmingly, the industry commented upon the nonconfrontational atmosphere of the DOI and their willingness to work out identified problems with the industry. An example is the Division's invitation to insurers for a walk-through of the Division. This practice allows the industry to put faces to names and creates a more open relationship in future regulatory matters. Other proactive measures such as a newsletter and educational seminars increase the insurance industry's knowledge of the rules and regulations. Although these activities are beneficial, they are self-policing mechanisms with limited enforcement usefulness.

This review found that in some instances the Division of Insurance is too passive in its enforcement duties. Too often the Division relies on self-regulation of the industry when evidence clearly identifies that it does not work. Enforcement of financial examination recommendations and premium tax collection are examples where enforcement is severely lacking. Additionally, the Division takes fewer enforcement actions against insurers and agents than surrounding states. When the Division does enforce the laws, it often operates very much in the reactive role. Very few resources are allocated toward ensuring market conduct compliance by the industry. As a file and use state, this role is crucial to ensuring a strongly regulated community. Rather than attempting to correct problems prior to public harm occurring, the DOI will react after the damage has occurred. Consequently, most of their resources are focused on resolving consumer complaints with the industry.

Much of the lack of enforcement by the Division is due in large part to inadequate resources. As a result, the Division is forced to either abandon certain practices that are common to other states' insurance regulators or must create innovative measures that provide a regulatory presence but limited effective scope.

Consumer Affairs Enforcement Issues

The Division's lack of proactive efforts to evaluate agents and companies results in a greater burden to handle complaints and take enforcement actions. The DOI's regulatory functions to protect consumers can be summarized as follows:

> The Division reviews a large number of consumer complaints against insurance companies and agents, and the Division has a weak enforcement record.

Colorado licenses more producers, and Colorado companies write more premiums than most of the surrounding states. Comparatively, the Division receives a higher proportion of complaints. Yet, the Division conducts fewer enforcement actions than its neighboring states. Figure A compares the number of consumer complaints against insurance producers and companies for states surrounding Colorado. A ratio of the number of complaints received by the Division to the amount of premium written in the state indicates that Colorado is significantly higher than its neighboring states and states of comparable insurance size.

Figure A

STATE	Consumer Complaints	Premium Volume (in Billions)	RATIO
CO	7,715*	$ 9,833	.85
AZ	6,608	10,875	.61
KS	5,063	6,376	.79
NE	3,293	4,669	.69
NM	1,431	3,203	.43
TX	26,846	43,604	.62
AL	2,129	9,428	.22
OK	4,791	8,635	.54
LA	3,271	8,677	.37
TN	3,382	11,913	.27

Source: Most recent NAIC Insurance Department Resources Report, 1995 edition.

* Colorado's protest hearing complaint process is very accessible and the accessibility may result in higher complaints in the property and casualty section. The Division received 2276 in 1994.

A comparison of surrounding state actions taken against producers also reveals that Colorado's enforcement activities are relatively low. According to NAIC information submitted by each state insurance agency[5], Colorado licenses more producers in the state (over 42,000) and takes fewer actions against violating producers. (See Figure B.)

Figure B

STATE	*# of Producers*	*Suspensions*	*Revocations*	*Cancellations*	*Other*	*Fines*	*Total Amount of Fines*
CO	42,831	3	3	0	5	15	$ 4,850
AZ	36,089	27	56	4	9	46	150,114
KS	29,835	2	20	0	12	17 1	15,900
NE	25,844	4	17	5	2	27	15,750
NV	21,862	6	0	2,620	2	2	650
UT	17,816	3	15	0	12	18	184,917
OR	24,172	0	13	0	15	15	53,000
LA	39,201	6	12	0	6	41	387,992
WY	5,677	180	7	0	0	13 3	27,050
TX	176,072	3	60	1	22	20	21,000

Source: NAIC Insurance Department Resources Report, 1995 edition.

Over the last year and a half, the Division has taken greater efforts at administrative action against producers. In FY 1995, DOI had approximately 100 total actions against producers. However, over two-thirds were against bail bond agents and of the one-third remaining, 27 actions were fines for late filing of licenses. The point remains that the enforcement record of the DOI against producers is not up to comparative standards.

Colorado also takes less enforcement action against companies than other states. Fines against companies are relatively few, and when they are assessed, they are fought vigorously by the insurers. Most often fines are assessed due to market conduct failures by the company.

[5] NAIC 1995 Report

The Division of Insurance responds to complaints through their Consumer Affairs Section. Divided into the Life and Health and Property and Casualty sections, there are 17 employees who respond to consumer complaints against companies and agents. Consumer Affairs attempts to resolve disputes through informal negotiation. If the company is at fault and negotiation fails, the Division, in theory, has the authority to compel the company into action through an administrative hearing or a fine. In practice, this rarely occurs. Without aggressive enforcement by the Division, consumers may not be receiving an adequate response to their complaint. Passive responses to consumer complaints may satisfy the consumer because they feel nothing more can be done. However, if the Division challenged more insurance disputes involving interpretations of statutes through administrative hearings, consumers would receive a better result.

There must be adequate resources available to the Division to attain a proper enforcement response. One reason for the low enforcement effort by the Division is the small number of legal resources available to the Division. A comparison of surrounding states reveals that Colorado should have at least twice the number of attorneys available to them for legal actions including market conduct examinations.

State Survey of Enforcement Attorneys

State	# of Attorneys*	1994 Total # of Employees**		1994 Total Premium
		Full Time	Contract Staff	
CO	2	84.5	3	$ 9,833,593,112
AZ	4	113	135	10,875,606,502
KS	6	172.2	1	6,376,085,203
NE	4.8	88	0	4,669,858,857
NV	5	43	34	3,541,508,382
NM	4	65	NA	3,203,797,553
UT	3	64	0	4,277,946,788
WY	2	24	6	902,207,598

* Identifies number of attorneys dedicated to insurance legal issues, includes Assistant AGs.
**Total employees denotes full-time and contract staff.

Recommendation #3: Create a Market Conduct Program Within the Division of Insurance

Because of the impact market conduct programs have in saving Colorado consumers money from overpaid premiums and the potential they offer for deterring insolvency problems, this report recommends that a market conduct program be established within the Division of Insurance consisting of six additional FTE whose jobs are to conduct market conduct examinations.

Summary: Another area where the Division could bolster their enforcement record is to conduct more market conduct examinations. As a file and use state, Colorado generally relies on the free market to determine rates. Reviewing market conduct practices is the major method to protect consumers against potential industry abuses. Target market conduct examinations are preferred in Colorado as well as many other states. These examinations look at specific market practices such as:

- Agent licensing issues
- Complaints
- Types of products sold
- Agent sales practices
- Proper rating issues
- Claims handling

A comparison of other states reveals that Colorado does not conduct nearly enough market conduct examinations. This is especially true considering that many regulatory requirements are self-evaluative/certified and rely upon the market conduct examination to ensure compliance. In FY 1994, Colorado conducted two market conduct examinations while in FY 1996/97 they hope to increase that number to fifteen examinations. The national average was 17 examinations per year. The effectiveness of market conduct examinations as an enforcement tool and their general support by all interests in the insurance industry strongly confirm that the DOI needs an in-house market conduct staff that would be supplemented by contract staff.

Discussion: As stated earlier in this report, lack of resources is a major reason for the inadequate enforcement record by the Division. The role of market conduct examinations by the DOI highlights this problem. One of the more essential proactive activities conducted by state insurance regulators to protect consumers is the market conduct examination. The market conduct process comprises two factors: 1) the examination process and 2) enforcement actions. The examination process reviews agent licensing issues, complaints, types of products sold by the company and/or agents, agent sales practices, proper rating, claims handling, and other market-related aspects of the insurance operation. When issues are identified through a market conduct examination, the DOI may take enforcement action against the company to correct the problem and to reimburse consumers for collecting improper fees.

The market conduct examination protects the consumer in two important aspects. By examining marketing procedures by the company, regulators can prevent larger market misconduct. Secondly, a market conduct examination can forecast potential solvency problems with the company. Because market conduct examinations look at problems on a more local area than financial examinations, the regulator can identify difficulties that in time could spread to other areas years after they would be reflected on a balance sheet. For example, a market conduct examination will review complaint data and note the number of complaints against a company resulting from delayed or improperly denied claims. The market conduct examination may also find improper claims practices, both of which could indicate cash flow problems of the company.

Because of their cost-effective consumer protection abilities, market conduct examinations have become increasingly popular throughout regulatory agencies. Unfortunately, Colorado has fallen behind in this activity when compared to other states. As quoted by the Colorado Commissioner of Insurance Jack Ehnes, "Market conduct examinations are one of the critically lacking functions of the department."[6] A national survey of states conducting market conduct examinations exemplifies his statement. On average, states completed 17.84 market conduct examinations in 1994. Colorado completed only two exams while initiating four. Currently, the Division is working with contract staff to attain a goal of fifteen exams per year.

[6] Committee Hearing, Feb. 3, 1996.

A review of the surrounding states also shows the lack of market conduct activity by Colorado. Comparing the number of premiums written in each state with the number of market conduct exams performed by other agencies further magnifies the situation.

1994 - # of Market Conduct Exams

Ranking in Premium	State	# of Market Conduct Exams Attempted	Completed	Staff	Contractors
22	AZ	230	102	1	40
30	KS	8	8	0	0
32	NE	18	13	6	0
38	NV	60	49	1	6
34	UT	21	20	3	0
52	WY	0	0	0	0
23	CO	4	2	2	0

Source: NAIC's 1994 Insurance Department Resources Report. This is the most current information available.

There are two general types of market conduct examinations conducted by regulatory agencies. Both are paid for by the insurer. Routine, periodic exams occur on a scheduled basis and cover every aspect related to the market conduct of the company. These exams require many months of intensive review by regulators. A second, more prevalent exam used by state agencies is the target examination. It is limited in scope to specific market conduct areas that the agency wishes to explore. The target exam will focus only on a specific area of concern such as a company's claims payout or the compliance of certain statutory rate requirements. These exams occur at the company's offices where regulators review a company's underwriting practices. This review includes their application of company practices to policies and claims handling activities, including marketing practices and training provided to agents by the company. Target exams require two full-time examiners and two additional part-time examiners to perform the review and take about two to three months to complete. In coordination with the market conduct exam, the Division requires legal counsel to answer procedural questions that arise during the examination as well as to provide legal interpretation of statutes. Additionally, legal counsel may be required to carry out enforcement procedures and corrective action.

The Division is committed to providing some type of market conduct presence within the regulated arena. Most states conduct targeted market conduct exams. In order to have an effective market conduct process, it is essential to have the necessary resources to conduct the examinations and to require corrective action against violators. The Colorado DOI's lack of resources to perform these exams has spawned innovative attempts by the Division to provide some type of regulatory oversight in this area. The result has been desk audits and internal audits.

Desk Audits

Desk audits review only policy forms of the company. Unlike market conduct exams, desk audits are performed within the Division. The Division will request that all policy forms used by the company be sent to them where analyst(s) will review the forms, Any problems are reported to the company where corrective action is taken. Desk audits can be a very effective tool but are limited in the regulatory scope. An example of these desk audits were the reviews conducted by the DOI on the credit insurance companies in 1995.

Internal Audits

A second market conduct activity performed by the Division is internal audits. These audits are conducted by the company and are self-evaluative in nature. The Division will request that a company review its claim files and books and identify any inaccuracies or incorrect market practices and refund customers who are affected. No immediate follow-up is performed by the Division to ensure that the company has reported accurately. Ideally, future market conduct examinations would review these companies' findings, but the likelihood of that occurring with no current market conduct resources is tenuous. Both desk and internal audits provide useful tools as supplements to market conduct examinations. However, on their own, they lack the scope and integrity to adequately review market conduct practices.

Colorado Market Conduct Experience

It should be noted that Colorado's limited experience with the market conduct process has been quite successful. In FY 1994, the DOI conducted two market conduct examinations on State Farm Fire and State Farm Mutual Insurance Companies. As a result of these exams, the company instituted training and changes in internal procedures to improve compliance with insurance laws. Benefits to the public resulting from the market conduct examinations included:

- Reduced delays in claims payments. In addition to revising its procedures, the company invested approximately $300,000 in claims processing personnel,

- More insured drivers because of fewer rejections of applications for insurance,

- Fewer uninsured motorists due to closer compliance with statutes governing nonrenewal of policies,

- Better disclosure of policyholder rights to protest a company increase in premium, cancellation of coverage, or increase in deductibles,

- Premium savings to insureds through a reduction in errors in surcharges applied to policy premium amounts,

- Continued coverage for policyholders as a result of improved compliance with statutes that limit reasons for cancellation,

Refunds to insureds for deductibles recovered through subrogation proceeding,

- Protection to insureds by the assurance that copayments will not be made to a repair facility without the insured's permission,

- Greater accuracy in the development of auto premium rates by more precise coding of the company claim data,

- Full payment of benefits because of greater accuracy in total loss calculations and better documentation of the basis for claim payments or denials,

- Uninterrupted medical care as a result of timely payment to providers, and

- Payment of a $35,000 monetary penalty to the General Fund.

In FY 1995, the DOI conducted desk audits of 20 of the 100 credit insurers in the state. Of the 20 companies examined, 16 were found to be in noncompliance with statutory premium level rates, and 9 of the 16 subsequently achieved compliance through changes in underwriting practices and rate reductions. Most importantly, the desk examinations resulted in refunds to consumers of thousands of dollars in excess premiums. One company refunded $100,000. Additionally, thousands of dollars in premium dollars were saved by consumers through corrected rating procedures identified from the examination.

The DOI conducted one other market conduct examination of the Dairyland Insurance Company. The Division discovered many apparent violations of Colorado insurance laws which led to corrections and changes in company practices and will benefit Colorado consumers through premium reductions and benefit changes.

Support for Market Conduct Examinations

Unique to other types of insurance regulation, market conduct examinations are supported by the industry, consumer associations, the NAIC, and the Division of Insurance. Consumers see these exams as a strong tool against potential market abuses while industry likes the uniform and clearly identified procedures and standards. In the past, industry has challenged interpretations by the Division of market conduct examination procedures and standards. Uniformity would eliminate many future problems in this area. Nationally, there were more than 1500 market conduct examinations conducted in 1994, an increase of 45 percent since 1991.

In 1995, the DOI created a task force comprising insurance companies, consumer advocate groups, health and property/casualty associations, legal associations, and the NAIC to review insurance regulation in the state. One of the results of that task force was a recommendation for the Division of Insurance to create a market conduct section composed of seven additional staff. A bill was created in the 1995 session and passed through the Senate. Unfortunately, the bill was postponed indefinitely in House Appropriations.

The DOI's commitment to a market conduct effort has resulted in a plan to hire outside contractors to perform the examinations. The Division's difficulty in acquiring competent and satisfactory examiners has stalled this process. Often these independent contractors are located around the country and training can be difficult to implement and coordinate. The complexity of the work makes it more difficult to coordinate a uniform regulatory program for the Division. This sentiment is also voiced by the industry, which prefers Division personnel.

Additionally, DOI employees would have easier access to training and this training could be continuous. As a result, the Division could hire individuals with less experience while providing continuous training for more experienced staff. Unfortunately, contract staff do not afford the same opportunity. However, contract staff are useful in offsetting the burden of in-house staff. At times it may be easier to use contract employees when performing a market conduct exam in another state. Rather than flying DOI staff to New York, the Division could hire an independent contractor living in New York and thereby eliminate certain costs.

Targeted market conduct examinations on an average take approximately two to three months to complete. There are two market conduct personnel within the DOI who oversee five contract employees. They are currently performing two market conduct examinations and have recently completed one other. By next year, the Division of Insurance plans to hire three additional contract examiners and conduct 15 more examinations. Although the direction by the Division is encouraging, with over 1700 companies operating in this state and as the only compliance check in a file and use regulatory system, it is imperative that the market conduct program be expanded.

Reviewing companies identified through the complaint process as well as performing follow-ups to company internal audits creates a significant demand for market conduct examinations. The reliance on market conduct examinations by the Division to identify noncompliance issues is appropriate, but unfortunately with so few conducted, they provide almost no regulatory oversight. Those that have been conducted have been overwhelmingly successful in saving consumers money. One can imagine how much more successful they could be if conducted regularly. Although the increase in costs is considerable, the savings to consumers will more than pay for this program.

Recommendation #4: Increase Credit Insurance Minimum Loss Ratio Standards From 40 Percent to 60 Percent

This report recommends that §10-10-109(2), C.R.S., be amended increasing all lines of credit insurance minimum loss ratio standards from 40 percent to 60 percent.

Summary: Credit insurance has become an increasingly popular form of insurance sold to Colorado consumers. There is approximately $70 million dollars of credit insurance sold to Colorado consumers.

Reverse competition of credit insurance requires Colorado, like all states, to approve credit insurance rates prior to their use. Rates are regulated through loss ratio standards set by each state. A comparison of credit insurance rates of other states reveals that Colorado has the lowest minimum loss ratio standard in the country. While many states require a 60 percent loss ratio standard and some states require as high as an 80 percent standard, Colorado's minimum loss ratio standard is only 40 percent. The consequence of such a low rate results in Colorado consumers paying more for their insurance than consumers in other states. Higher rates cost Colorado consumers millions of dollars a year in overpriced credit insurance. This report identified a 60 percent loss ratio as a more reasonable standard for Colorado. This rate is also supported by the NAIC, which studied the issue nationally.

Discussion: When a consumer purchases goods on credit by borrowing money from a bank or finance company (including using a credit card), the consumer is often solicited to buy credit insurance. Credit insurance is designed to ensure the payment of the consumer’s debt in the event of death, disability, or some other hardship.

Types of Credit Insurance

The two most common types of credit insurance are credit life insurance and credit accident and health insurance (called disability). Credit life insurance is insurance on the life of the debtor in connection with a specific loan or purchase. If the debtor dies, the insurance will pay the value of the loan or purchase. Credit disability insurance is insurance on a debtor to provide indemnity for payment coming due on a loan or credit transaction while the debtor is disabled. The creditor will make the installment payments as long as the insured remains disabled.

Colorado insurers also provide credit property insurance and credit unemployment insurance. Credit property insurance covers damage to consumer goods purchased on credit or pledged as collateral for a consumer loan. Credit unemployment insurance covers payments on a loan or credit transaction while the debtor is out of work.

Reverse Competition

Under traditional market forces, there is a certain supply and demand for goods which determines a reasonable price of the product. These traditional market forces do not work with credit insurance. The nature of the credit insurance industry creates a reverse competitive market which can lead to certain abuses in the sale of credit insurance. As such, states require stricter regulation than in most other lines of insurance. Under the credit insurance market, the seller of the product rather than the consumer chooses which insurer will provide the coverage. Consequently, insurers compete for credit insurance business not by lowering the price to gain consumers but rather by offering higher compensation to the creditor. This causes rates to go up unless monitored and controlled by the state.

In other lines of insurance, the consumer has the opportunity to price shop and make a determination as to what and from whom to buy the insurance. Credit insurance is bought and sold very differently. Credit insurance is sold to retailers/creditors in group policies. Between 90 and 95 percent of all credit insurance is purchased as group policies. This makes it prohibitive for a consumer to purchase insurance on his or her own. For example, a consumer wishing to purchase an automobile on credit and who wants credit insurance must purchase the insurance from the automobile dealer. The same applies if the consumer wishes to purchase a house on credit. In that situation, the consumer must purchase the credit insurance from the lender.

The result is the retailer/creditor of the credit insurance becomes the insurance company's customer. This removes the consumer from the process, and there is no incentive for the insurance company to offer a lower price for their product. Rather, the insurance company will provide incentives to the seller by providing higher commissions in order to have their product selected over another. Commissions to sellers of credit insurance within Colorado reach as high as 50 percent.

Regulation of Credit Insurance

Because of this reverse competitive market effect, all states regulate the price of credit insurance. The two traditional methods of regulation, and the methods used by Colorado, are the minimum loss ratio standard and the use of prima facie price rates. These minimum loss ratio standards and prima facie rates work together to determine how much value the consumer will get for each dollar of insurance purchased.

The minimum loss ratio is the amount of losses in claims paid out by the insurance company related to the amount of premium dollars the company collected. If the minimum loss ratio is 40 percent, then for every $1 million in premium collected, the company must pay out $400,000 in claims. The importance of the loss ratio standard is that it provides a check on the amount of profit a credit insurance company may make on consumers. Colorado's loss ratio standard is the lowest in the country at 40 percent. Over the last several years, states have increased their minimum loss ratio standard in an effort to provide the consumer a more equitable rate. Many states currently set minimum loss ratio standards between 50 and 60 percent while some states are as high as 70 to 80 percent. All states set a prima facie rate for life and accident and health coverages.

The second form of regulation which coincides with the minimum loss ratio standard is the prima facie rate. The prima facie rate is a fixed rate that insurance companies may charge for their product. These rates are identified in rule or statute and are used as a base line rate for all companies offering the particular product. Insurers must receive regulatory approval to charge a rate above the prima facie rate. For example, if a prima facie rate for credit life insurance is 0.50, that means that the credit insurance company is limited to charging 0.50 for every $100.00 of indebtedness. The goal of states setting a prima facie rate is to attain a specific minimum loss ratio standard identified in rule or statute. In Colorado, once a company has a rate history, the company must then meet the minimum loss ratio standard. Other states presume that the insurer meets the minimum loss ratio if it follows the prima facie rate.

Minimum Loss Ratio Standard:

Amount of Money Insurer Pays in Claims
Amount of Premium Collected by Insurer

40% Minimum Loss Ratio Standard = $\frac{\$400,000}{\$1,000,000}$ **= $0.40 / $1.00**

Prima Facie Rate: Statutory rate insurers may charge for insurance. In Colorado, this rate may be used until the company has claim history for specific insurance line, then the company must use the minimum loss ratio standard. The prima facie rate results in a lower loss ratio than the minimum loss ratio standard.

Regulation of Credit Insurance in Colorado

Colorado currently regulates all forms of credit insurance in the state. In 1994, insurers wrote over $58 million in credit life insurance and credit accident and health insurance and slightly more than $14 million written in other types of credit insurance.

Amount of Credit Insurance Written in Colorado[7]

Insurance Type	Amount of Premium Written in 1994
Accident and Health	$30,552,278
Life	27,585,342
Involuntary Unemployment	8,000,000
Property and Casualty (including Collateral Protection Insurance)	6,300,000
Total	**$72,437,620**

[7] Disability and life figures from NAIC. Involuntary and P&C numbers from Gary Fagg.

Prima facie rates for credit life is 52 cents for every $100 of liability sold and credit accident and health ranges from 80 cents to $2.30 for every $100 of liability sold, depending on the type of coverage. The minimum loss ratio standard is 40 percent for all types of credit insurance. On the average, when comparing loss ratios of credit insurance to other insurance lines, credit insurance has a much lower ratio. Loss ratios for auto rates are approximately 90 percent and homeowner rates are between 85 and 90 percent.

Two years ago, the Division of Insurance conducted market conduct exams of 20 credit insurers. Results of those examinations identified that 16 (80 percent of the insurers) were charging higher rates than allowed by statute resulting in thousands of dollars of excess premiums.

Colorado Consumers Overpay for Their Credit Insurance

A comparison of other states reveals that Colorado consumers pay more for their credit insurance than most other states. In FY 1994, for every dollar that consumers in Colorado paid for credit life insurance, they received 36 cents.[8] Contrasting that with the national average, consumers received 42[9] cents for every dollar paid for credit life insurance[10]. Some states such as New York and Maine require that the consumer receive 75 cents of value for every dollar of premium paid.[11] In 1994, the Consumer Federation of America, a national insurance consumer organization, noted that in most states, credit life insurance is still overpriced and consumers should be receiving 60 cents for each dollar in premium paid.[12] The NAIC has also reviewed this issue and its model legislation identifies 60 cents as the rate of return for consumers.[13]

[8] Rate determined from the NAIC Credit Life and Accident and Health Experience by State 1992-1994 Report (November 1995) "Calendar Year Loss Ratios- Prima Facie" column.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Consumer Federation of America, July 25, 1994, News Release.
[13] NAIC model Legislation for Credit Insurance.

A comparison of the value Colorado consumers received from credit life insurance to the national average reveals that consumers in Colorado paid over $1.65 million more for their credit life insurance. By using the NAIC-supported number of 60 cents in consumer value, Coloradans would save $7.7 million a year.

Consumer Return on Credit Life Insurance

	Consumer Return Per Dollar	Relative Overpayment by Colorado Consumer
Colorado	.36	
National Average	.42	$ 1,655,120
Arizona	.56	5,516,868
NAIC Model Legislation	.60	7,723,895
New York	.75	10,758,283
Maine	.80	12,137,110

Credit accident and health insurance reveal similar outcomes. Colorado citizens who purchase credit accident and health received 42 cents of value for every $1.00 they paid while the national average was 50 cents for every dollar of value paid.

Colorado credit life insurance companies wrote over $27 million in premiums in 1994. Raising the loss ratio standard from its current level of 40 percent to 60 percent would save Colorado consumers $5.7 million a year on credit life insurance purchased in the state alone. Colorado accident and health insurers wrote $30 million in premiums in 1994. Imposing a 60 percent minimum loss ratio standard, consumers would save $5.5 million a year. Total savings to consumers in credit accident and health would increase that total to over $11 million.

Other States Regulate Lower Rates Yet Incur Higher Losses

Critics of a higher minimum loss ratio standard will state that such a large decrease in premium payments will prohibit companies from offering the insurance to consumers. Furthermore, critics will state that the cost of offering the insurance in the state will be too high. A comparison of other states' prima facie rates and insurer losses does not support these assertions. There are a number of states throughout the country that come close to meeting or exceed the 60 percent threshold, and they still have insurers providing these products. Additionally, these states have much higher claim losses than Colorado, making it more expensive for insurers to currently operate in those states.

Credit Life and Accident and Health

State	Number of Credit Insurance Companies	Life Prima Facie Loss Ratios	Life Premiums Written	Accident and Health Prima Facie Loss Ratios	Accident and Health Premiums Written
CO	100	35.7	$ 27,584,342	42.1	$ 30,552,278
AZ	85	56.2	31,096,451	39.6	27,327,416
MD	77	53.6	37,516,479	42.7	38,573,012
ME	10	75.2	6,314,637	63.5	13,743,701
NJ	57	59.9	44,581,919	71.9	53,305,324
NY	30	76.0	61,648,609	62.2	88,491,059
RI	54	70.8	4,424,966	48.4	5,376,087
VT	37	58.4	3,127,866	63.2	5,012,193
MI	75	52.6	112,802,406	67.2	157,400,651
PA	71	57.6	114,612,606	75.0	135,771,979

Other Lines of Credit Insurance

Insurers sold other lines of credit insurance to consumers. Credit involuntary unemployment and credit property insurance premiums exceeded $14 million in premiums written for 1994. These insurance products are offered in the same manner as credit life and disability insurance and are subject to the same reverse competition issues. Increasing the minimum loss ratio would provide additional savings to consumers.

Recommendation #5: Create a Consumer Advocate Within the Office of Consumer Counsel

This report recommends that the General Assembly create an insurance consumer advocate within the Office of Consumer Counsel to provide consumers more input on insurance issues.

Summary: This Sunset Review found that consumer interests related to insurance matters are not adequately represented in the political and regulatory processes. There is little consumer input in Colorado to provide consistent and adequate representation on insurance issues. Although the Division of Insurance makes consumer protection its mission and the Division strives to achieve this goal, its role as a regulator restricts it from acting as a true advocate for consumers. Consequently, prioritization of workload and use of resources are allocated differently as a decision maker than as an advocate. In an effort to provide more balanced input in determining future insurance decisions, there is a need for a consumer advocate.

***Discussion*:** Insurance in today's society is a complicated and large industry that pervades many aspects of everyday life. In many circumstances, insurance is required either by statute or through common industry practice. For example, all citizens who operate automobiles in Colorado are statutorily required to possess auto insurance. Homeowner insurance is virtually mandatory, since it is required through federal statute if obtaining a federal loan or required as industry practice if obtaining a mortgage. Not only is the role of insurance broad, but knowledge of its practices and operations is extremely complicated. Whether an insurer is financially sound, whether insurance rates are fair and reasonable, and whether the consumer is getting what he or she purchased comprise many of the issues that confront the public. The Colorado General Assembly determined that the average citizen does not have the resources or expertise to make an informed decision about these issues without regulatory assistance. For this reason, Colorado requires specific reporting requirements from insurers about their solvency and their market conduct. In other situations, the state mandates insurance coverage for some areas such as auto insurance. This mandate creates a heightened responsibility by the state to ensure that the consumer is protected.

Over the last few years, there have been a number of bills introduced into the General Assembly that have called for a higher regulatory scrutiny of the insurance industry through a consumer advocate. This request has been spawned by the large dissatisfaction from the public with the insurance industry. Last year, the Division received over 7000 written complaints related to insurance while it received over 60,000 telephone inquiries. The role of that advocate has varied depending upon the bill. Last legislative session, a proposal for a consumer advocate to review rates was postponed indefinitely. A consumer advocate was supported by the Colorado State Auditor in its 1987 audit report.

One point used to support these proposed bills has been the need to level the playing field between the special-interest lobbyists and the consumers. In Colorado, as elsewhere, the insurance lobby is very large and powerful with many resources. They are a constant presence at the Legislature and offer compelling arguments supporting their positions on insurance issues. Additionally, the insurance lobby has a strong presence with the Division of Insurance and the National Association of Insurance Commissioners and provides input to the NAIC on various insurance issues. The insurance lobby provides a useful mechanism for obtaining information relevant to the issue being reviewed. Like all lobbys, however, they present information favorable to their position. When competing interests are represented, decision makers can weigh the different information and make informed decisions. Unfortunately, different insurance interests are not equally represented. On the state level, the insurance consumer lobby is virtually nonexistent. Some special interests such as the American Association of Retired People (AARP), the Colorado Public Interest Research Group (COPIRG), and the Colorado Trial Lawyers Association (CTLA) provide some consumer interest support, but these groups have limited agendas or have neither the resources nor expertise to provide effective universal review of insurance regulation and policy. The Division of Insurance makes a concerted effort to seek out consumers for task forces used to make policy changes. The DOI finds that locating knowledgeable consumers is very difficult, and the result is limited informed consumer input.

Many of the same arguments can be made at rule-making hearings. There is a continuous presence by the insurance industry advocating their position to the agency, but rarely, if at all, is the agency hearing from the consumer. Instead, the Division must assume that role along with its role as regulator.

The insurance industry has argued in the past that there is no need for a consumer advocate because the Division of Insurance is already performing that function and thus such a position is unnecessary and superfluous. As discussed earlier, the statutory direction of the Division requires it to promote insurance competition while at the same time protecting the public welfare. The Division's dual roles as a protector for consumers and a promoter of insurance competition are inherently in conflict with each other. As identified by the Colorado State Auditor in 1987, *"consumers cannot be represented by the Division for the following reasons:*

- *Division staff must balance the interests of the consumer and the industry, as part of their regulatory responsibility.*

- *Consumer complaints are handled in the Division on a case by case basis.*

- *Division staff are not in a position to question the decisions of the commissioner or policies of the Division.*

- *The Division cannot effectively be both the regulator and the consumer advocate. The two roles are mutually exclusive. On one hand, the Division is charged with ensuring that the legitimate interests of both the industry and the consumer are met. On the other hand, a consumer advocate must work for the interests of the consumer above all others."*[14]

[14] Colorado State Auditor's Report of the Division of Insurance, 1987, 78.

The Division disagrees with this determination and believes it is effective in both roles. While the Division's mission is consumer protection and the Division does an admirable job pursuing this goal, there is a subtle yet distinct difference between consumer protection and consumer advocacy. As decision maker, the Division is restricted in its role as an advocate. Prioritizing workload and use of resources are balanced differently as a regulator than as an advocate. This distinction is illustrated through the Division's role in reviewing proposed legislation. Each year there are numerous bills affecting the DOI (last year there were over 70 bills). At times the Division may meet with legislators privately or occasionally testify at legislative hearings regarding the merits of the bill. Often this testimony will center around the fiscal impact the bill will have on the agency. Many times the Division will remain neutral on proposed legislation. Very few times will the Division address how the bill will impact the consumer. A consumer advocate would not remain neutral and would testify at each bill hearing and explicitly state whether the bill is good for consumers and why. Without a constant presence at legislative hearings testifying on the bill's effects to the consumer, the Division's role as advocate is severely diminished.

Insurance issues are exceedingly vast, and future decisions will have substantial impact on the consumer. Aside from the general classifications of insurance such as property and casualty, health, disability and life, there are numerous issues associated with each classification. In health care alone, future policy decisions will be made on such topics as health maintenance organizations (HMOs), nonprofit carriers, consumer disclosure plans, and genetic testing. The same is true in property and casualty lines where issues of automobile rates, homeowner policy disqualification, and personal injury protection limits dominate the discussion. All of these issues affect the consumer and require a broad class-based policy decision. The role of shaping this policy is beyond the limited capacity of the Division of Insurance. The need for balanced input is essential in determining fair and reasonable direction for future insurance regulation.

The constant presence of the insurance industry advocating its position, the lack of consumer input in policy-making decisions, and the Division's inability to adequately perform that function strongly suggest a compelling need for a consumer advocate to assist in the future of the dynamic nature of insurance.

Another aspect often suggested for a consumer advocate is to review rates and forms. HB 96-1310 from the prior legislative session proposed that the Office of Consumer Counsel be enlarged to provide rate and form review over the insured community. Much of the impetus for a consumer advocate to review rates lies with two interconnected aspects of insurance: the high cost of rates in Colorado and the limited free market conditions of the insurance industry. Auto insurance is one line of insurance that proponents espouse would benefit from a consumer advocate. Colorado has one of the highest auto insurance rates in the country, and the top six companies write approximately 70 percent of the business. Proponents point to the Office of Consumer Counsel in the utilities area and the impetus for their existence as similar to a need for a consumer advocate in insurance. The OCC was created because of the restricted market for public utilities companies in the state and the industry's potential for abuse against consumers.

Under the current regulatory approach, the Colorado General Assembly's philosophy has been that the free market should dictate the price whenever possible. Consequently, most rate and policy changes follow a file and use system. Only in specific cases where there is little free market forces, such as credit insurance and Workers' Compensation, does the state require prior approval by the Division of Insurance before a new rate or policy may be used by the insurer. As a result, only a portion of rate and form filings are ever thoroughly reviewed by the Division of Insurance.

Proponents of a consumer advocate have suggested in the past that it review rates. This would essentially have the effect of making Colorado a prior-approval state. This report's review of auto rates in other states revealed that there were too many variables to adequately determine if prior approval results in more savings to consumers than a file and use system. If a more detailed review could show benefits to prior approval, it would be better to increase the staff of the DOI to address this issue than to place this function with a consumer advocate. This may be one task that a consumer advocate would investigate as part of its duties.

Finally, in order to make an adequate determination and assessment of future insurance issues, it is necessary for the consumer advocate to have access to Division of Insurance records. Access would not be used to investigate individual complaints but rather to perform effective analysis on broader policy issues.

Recommendation # 6A: Amend §12-7-109(1)(G), C.R.S., to Make it Unlawful for Licensed Bail Bond Agents to Write Bonds in Any Court of Record When They are in Forfeit of a Bond and to Prohibit Courts From Accepting Any Bonds From Bail Bond Agents and Sureties When a Bail Bond Agent or Surety is in Forfeit of a Bond

Recommendation #6B: Merge Bail Bond Program Sunset Date With Division of Insurance Sunset Date

Summary: Collection of bail bond forfeitures by the courts and against the bail bond agent has historically been a problem in Colorado. The current statutory methods to address this issue are inappropriate and inefficient. Administrative action to remedy the problem has not produced the desired effect and is a costly and burdensome process for the agency. In 1995, the courts declared 273 forfeitures of bail bonds, ordering the Division to take administrative action against the bail bond agent's license. These activities use up considerable Division resources. This report believes the court system is a more appropriate place to address forfeiture issues and those courts that have programs in place have been highly successful in almost eliminating forfeitures in their courts. As a result, this report recommends that §12-7-109(1)(G) C.R.S., be amended to direct the courts to order bonding agents and their sureties from writing bonds in any court's jurisdiction until the forfeited bond is paid in full. This approach should protect the interests of the bail bond industry, expedite the payment of revenues due the courts of record, and provide for the efficient allocation of resources to address areas of public concern in the Division of Insurance.

The bond program has a separate sunset date contained in §12-7-112 C.R.S. Since bail bond agents are regulated by the Division of Insurance and both are subject to sunset reviews, DORA recommends that future sunset dates for these two programs be conducted during the same year or in the alternative, merged as one sunset review.

Discussion: One of the more controversial bills during the last session of the General Assembly was the continuation of the licensing of bail bond agents. Resulting from a sunset review a year ago, a bill was passed that continues the regulatory program of that profession. As part of the Division of Insurance, and subsequently part of this review, this report thought it necessary to revisit some of the issues identified in DORA's 1995 report that either were not addressed fully during the sunset hearings or have subsequently evolved to warrant additional attention.

While reviewing the Division of Insurance's handling of complaints against producers and companies, it became obvious that a disproportionate amount of resources are used by the Division to resolve complaints or to take disciplinary action against bail bond agents and companies. In 1995, there were 320 bail bonding agents in Colorado. Yet, the Division received 389 complaints against bail bond agents that year.

Comparing these numbers to complaints received against all other insurance agents, the information is compelling. In 1995, there were over 42,000 licensed insurance producers in the state, which resulted in 36 Division actions ranging from fines to suspensions to revocations of licenses. The Division took almost twice as many actions against bail bond agents as against other insurance producers, and bail bond agents make up less than 1 percent of all agents licensed in the state.

1995 Producer Actions						
Number	Total Actions	Fines	Suspensions	Revocations	Probation	Surrendered License
42,831	36	27	2	1	3	6
Bonding Agents						
Number	Total Actions	Fines	Suspensions	Revocations	Probation	Surrendered License
320	62	38	17	1	1	3

Complaints against bail bond agents primarily fall into three distinct categories: 1) consumer complaints, 2) administrative complaints, and 3) bail bond forfeitures. Consumer complaints against bail bond agents, such as complaints alleging theft of premium and failure to return collateral, make up a rather small portion of the total number of complaints received from consumers. It is believed by the Division that consumer complaints do not accurately reflect the true number of complaints against agents. The Division believes that consumers are unaware of their rights as consumers and do not know whom to contact with complaints. The Bail Bond Advisory Committee (repealed by the General Assembly in 1995) identified these problems and, along with the Division, discussed creating a brochure on consumer rights which would also provide the DOI's complaint telephone number. Additionally, the bail bond agent wields enormous power by having the ability to pull the bond at his or her discretion and thereby sending the individual back to jail. Consequently, individuals may fear retaliation if they complain about unethical or illegal bail bond activities.

Another significant number of complaints are initiated by the Division itself. These are administrative complaints and include such activities as falsifying reports and failure to file semi-annual reports, felony arrest records, and applications for licensure.

BAIL BOND INVESTIGATIONS CASES				
Year	Consumer Complaints	DOI Complaints	Forfeitures	TOTAL
1992	11	71	541	623
1993	19	106	479	604
1994	53	140	511	704
1995	34	74	273	381

Complaints against bail bond agents primarily were received from Colorado courts where the agent failed to obey court-ordered forfeitures. Over 70 percent of the total complaints resulted from forfeitures. The most significant resource allocation against the DOI related to bail bond agents is the forfeiture issue. Under the current system, when an individual posts bail through a bail bond agent and fails to show up for his/her court appearance, the judge may declare a forfeiture by the agent providing there is a "show cause" hearing. §16-4-103(3), C.R.S. [15]

The "show cause hearing" must occur within 20 days, and the judge can provide additional time for a bail bonding agent to find the defendant, vacate the bond, or enter a judgment forfeiting the bond. If the bond is forfeited, the court orders the bail bonding agent to pay the amount of the bond to the court within 45 to 90 days. If the bail bonding agent fails to pay, the court files a complaint with the Division of Insurance to take administrative action. Forfeiture complaints occur at this juncture when the bail bonding agent fails to cover the forfeited bond.

Once the court declares the bond to be in forfeit, the court will order the Division of Insurance to suspend or revoke the bail bonding agent's license. §12-7-103(3)(b), C.R.S. This sets in motion administrative legal action by the Division including investigating the complaint and preparing for an administrative hearing. Each administrative action for revocation or suspension of an agent's license on the average takes 8 to 12 months to complete. Investigating a complaint requires considerable resources and involves personnel from the DOI's investigation and licensing units.

[15] §16-4-103(3) states that when a defendant fails to appear, the court judge "shall issue notice of declared forfeiture or judgment and afford an opportunity for hearing under §16-4-110, C.R.S., to all persons pledging security for the defendant's appearance, to show cause, if any, why their security should not be declared forfeit, and due the court."

Additionally, resources from the state's Attorney General's Office and the Division of Administrative Hearings are needed. Ironically, these resources are used to obtain a second judgment as well as to secure a payment on a bond previously forfeited by the court.

During the time the bond is in default, the bail bond agent is prohibited from writing new bail bonds. In the past, it was common practice for the agent to continue to write bonds, since no timely or efficient manner exists to notify the over 300 court offices of the action, and there is no existing method to confiscate the agent's license. To address this issue, changes were made last year to the statute, which now requires that the surety be directly notified when forfeiture has been entered by the court. Although this will provide some benefit, further changes to the statute are necessary.

The current system of addressing the bail bond forfeiture issue has proven to be ineffective and inefficient. It provides for an administrative remedy when a court order fails. This is contrary to other enforcement actions taken by the state. Generally, the administrative action is used first, and when that fails, stronger actions such as court orders against the defendant are used. Under the bail bond forfeiture laws, when civil action fails, the court reverts to the lesser administrative action. Consequently, an unnecessary and duplicative process is used to correct the problem that can and should be properly handled by the courts.

The major problem with the forfeiture issue is that the remedy obtained by the state is not the remedy sought for the action. The administrative process is a very time-consuming and costly procedure. Under the current system, a forfeiture results in the administrative action of revoking or suspending the license in an attempt to get the reimbursement of the bond to the court. A review of the Division's success at attacking this problem over the last few years clearly shows that administrative actions alone do not eliminate the forfeiture problem. Rather, the courts are better able to direct a quicker and more appropriate resolution to forfeitures. As stated in the Bail Bonding Agent Sunset Report last year, "the courts are the chief beneficiary of forfeited bond collections and should therefore be the principal actors in the process."

Some courts in Colorado have enacted programs to address the bail bond agent forfeiture issue and have been much more successful than the Division at curtailing the number of forfeitures in their jurisdiction. The Denver County and District Court's ON THE BOARD program is one example of a local court's ability to actively reduce forfeitures. Under this program, any bail bond agent whose bonds are declared forfeited as well as any other bonding agent writing for the same surety insurance company, is prohibited from writing any bail bonds in the Denver City and County court's jurisdiction until the bond amount is paid in full. This system provides a two-prong approach against the

agent whose bond is forfeited. First, the agent is not able to write bonds in that court. Second, the prohibition of other agents under the same surety insurance company to write bail bonds acts as peer pressure for the forfeiting agent to pay the bond. Denver's ON THE BOARD program has been very successful. This jurisdiction has the highest volume of bail bonds written in the state, and in 1994 and 1995 they had no bail bond forfeitures. Additionally, collection of forfeited bonds by the court more than paid for the program.[16]

Because courts could be more effective at addressing bail bond forfeitures, DORA recommends amending the Colorado Revised Statutes to make it unlawful for a licensed bail bond agent to write bonds in any court of record when they are in forfeit of a bond and to prohibit courts from accepting any bonds from bail bond agents and sureties when a bail bond agent or surety is in forfeit of a bond.

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[16] "As referenced in Recommendation 2, last year the Colorado Division of Insurance received a total of six hundred fifty-six complaints on bailbonding agents. An overwhelming four hundred eighty-five of these complaints were from Colorado courts on unpaid bail bond forfeitures. This amounts to seventy-four percent of all the complaints against bailbonding agents received by the Division. Each of these complaints is investigated over an eight to twelve month period, involving the Division's investigation, legal services, and licensing staff, the State Attorney General's Office, and the resources of an Administrative Law Judge to secure a second judgment and payment on the same forfeited bond...

The data suggests that the majority of courts elect not to invest resources in the collection of forfeited bonds and instead refer complaints to the Division of Insurance. This fact was borne out through interviews with bail bonding agents and with county court officials. Bail bonding agents reported that in cases with special circumstances, complaints are often filed with the Division without their receiving due process or a notice. Court officials reported a lack of centralization and resources as the major reason for their not pursuing collection efforts at the court level. The Department believes that if the Division can work with court systems and provide assistance in enhancing existing programs and procedures these negative economic impacts can be reduced.

Further investigations on this challenge led to the discovery of a possible model program. The Denver County and District court bail bonds office initiated the ON THE BOARD PROGRAM in 1992. While Denver courts have the greatest volume of bail bonds written, there were 16 complaints forwarded to the Division in 1993 and no forfeited bond complaints forwarded in 1994. In interviews with the Denver Bail Bonds Office, it was learned that bond forfeitures do occur at normal industry levels. This program, however, uses a strong but fair collections approach, maintains a central point of information on unpaid forfeited bonds, and uses peer pressure to ensure prompt payments. The bonding office is also quick to correct its mistakes by refunding moneys collected in error.

Specifically, the program operates in the following manner: When a judge has chosen to declare a bail bond forfeited, the bail bonding agent is expected to make prompt payment to the court. If after approximately seven days payment is not made, the agent is contacted in writing and verbally, and directed to make payment immediately. If payment is not received, the bail bonding agent is called the day before his name is placed on 'the board'. These calls are made every Monday and Wednesday and 'the board' is posted on every Tuesday and Thursday. If an agent is listed on 'the board' that bail bonding agent and all other bail bonding agents writing for the same surety insurance company are prohibited from writing ANY bail bonds in the Denver County and District Court system, until payment is made in full.

Surprisingly, this program is accepted and respected by representatives of the surety insurance companies, and by bail bonding agents themselves. The only criticized aspect of the program is the denial of bail bonding privileges of all other bail bonding agents writing for the same surety insurance company instead of the individual offenders. The bail bonds office reported that this is a new aspect of the program and that it generates a significant amount of peer pressure to ensure payment of forfeited bail bonds.

The ON THE BOARD PROGRAM has proven to be an efficient and effective court-based collection effort. In 1993, a total of $411,038 and in 1994, $398,505 in forfeited bond payments were collected and deposited into the court's general fund. The program's operating budget in 1993 was $425,000 and in 1994 was $355,000, demonstrating this program's overall self sufficiency. The materials needs for this program include a telephone and one clip board. Personnel resources include the full-time coordination effort of one clerk and supporting efforts from two additional clerks."

Recommendation #7: Implement Uninsured Motorist Database

Implement an electronic tracking of valid insurance on all registered vehicles through authorized insurance companies and the Department of Revenue, Motor Vehicle Division.

Summary: The current system for verifying that an automobile or driver is covered by a valid insurance policy is antiquated, inefficient, and easy to circumvent. Proof of Insurance cards sent out by insurance companies at renewal time contain an expiration date that is only valid if the premium is paid. A vehicle owner can easily cancel the policy or simply not pay the premium. However, the owner can still produce what appears to be a valid proof of insurance if requested by law enforcement officials.

Proof of Insurance cards frequently get lost, misplaced, or accidentally destroyed. In the Aurora survey, approximately half of the vehicles ticketed for failure to have proof of insurance were able to document coverage at a subsequent hearing. The effort to demonstrate valid insurance wastes consumer time, as well as law enforcement and court resources. It would be more efficient to have insurance information immediately available to law enforcement agencies. (See Discussion commencing on page 102.)

Recommendation #8: Authorize the Commissioner to Impose Fines for Violations of Financial Solvency Statutes or Regulations

Summary: The number of financial examinations performed by the DOI each year range from the high teens to the mid-twenties. The majority of these examinations reveal technical violations of statutes or regulations. Colorado law provides no specific penalties for violations found in a financial examination. The Commissioner may, if the violation is serious enough, take action to suspend or revoke the license of an insurance company based on the financial examination. The possibility of action against a company's license presumably provides sufficient inducement to voluntarily correct all deficiencies.

As part of the research for this report, a review of published financial examinations was conducted. Typically, examinations revealed violations of regulatory requirements with varying degrees of severity. A review of subsequent examinations by the DOI discovered failure of insurance companies to comply with orders of the Commissioner. The possibility of monetary penalties will provide a greater incentive for compliance than the possibility of action against a license for minor violations.

***Discussion*:** Insurance company, particularly life insurance company, failures were rare from the 1940s to the 1970s. This changed sometime in the 1970s, according to a study by the A.M. Best company. From 1970 to 1980, 108 P&C companies were insolvent; from 1980 to 1990 that number more than doubled to 226. The 1990s started off at a pace to exceed the previous decade.

The failure of two high-profile life insurance companies, Executive Life and Mutual Benefit Life, in 1991 prompted renewed interest in federal oversight of the insurance industry. The U.S. House Committee on Energy and Commerce, chaired by Congressman John Dingle, issued its report *Failed Promises* in 1990. The report was highly critical of state regulation and recommended a federal agency similar to the Federal Deposit Insurance Corporation to adopt uniform solvency standards and regulate reinsurance companies.

Legislation to implement *Failed Promises* proved unsuccessful. However, the controversy it created inspired the NAIC to create stricter guidelines for insurers and an accreditation program for state financial regulatory authorities. While the NAIC program has been criticized for being too soft, even critics agree the current standards are an improvement over the regulatory climate of the 1980s. Colorado was the first state in the Western Region of the NAIC to achieve accreditation.

The Commissioner has broad authority under the provisions of Part 2 Article 1 of Title 10, C.R.S., to conduct market conduct or financial examinations of insurance companies as often as necessary to protect the public. The commissioner is required to conduct formal financial examinations of every insurance company licensed in the state at least every five years. When a company is not domiciled in Colorado, the Commissioner may accept an examination supervised by an examiner from a state accredited by the NAIC.

Financial examinations are an essential function of DOI to protect the public. Financial insolvencies could have disastrous impacts on Colorado citizens. Private rating organizations, such as Moody's, A.M. Best, and Standard & Poor's, evaluate the financial condition of insurance companies and issue ratings. These evaluations are available to the public and are generally considered to be fairly reliable. However, many of the ratings are based on self-reported financial statements or reviews of state reports, rather than independent audits.

As a practical matter, most states examine only domestic insurance companies and accept the examination of the home state for foreign companies. The Commissioner has developed written guidelines for identifying companies to be examined. They include:

1. Any company identified by the DOI as high-priority. Companies identified by the NAIC early warning system and the NAIC Examiner Team as needing immediate regulatory attention and concurred with by the DOI.

2. Companies selected based on negative reports from the Financial Analysis and Actuarial Sections as well as consideration of each entity's financial condition, risk-based capital and surplus, results from prior examinations, and changes in operations and or management.

3. Examinations required by statute.

4. Companies whose last examination was three years ago.

Examinations are conducted using a team approach. Depending on the size of the company being examined, a team of two to five examiners will devote full-time efforts to a single examination. By statute (§10-1-204(2), C.R.S.), examiners have on-site access to "all books, records, accounts, papers, tapes, computer records, and other documents relating to the property, assets, business, and affairs of the company being examined."

The NAIC accreditation process requires the use of certain examination guidelines. DOI has incorporated these guidelines into its examination handbook, a more comprehensive guide than the minimum standards required by NAIC. Financial examinations provide an evaluation of an insurance company for a particular moment in time. The information contained in an examination report is likely outdated the day it is produced because examinations are conducted as of the previous year-end. However, it is a valuable tool to evaluate the financial soundness of an insurance company.

Colorado has approximately 80 domiciled insurance companies, most of which are headquartered in the state. Formal financial examinations evaluate reserves, claims procedures, investments, and compliance with regulatory financial requirements.

The DOI provides companies notice prior to an examination. This notice is followed by a request for documents from the examiner in charge of the assignment. The notification will usually request specific information be made available to the team with supplemental requests made when the team is on site at the company offices. Title 10 requires insurance companies to comply with information requests from DOI but does not specify a time frame or a specific penalty for noncompliance. The team leader may request documentation regarding compliance with recommendations made in previous examinations.

Once the examination has begun, the team will work with the company employees to verify compliance with statutory and regulatory requirements. Examiners will verify the accuracy of financial information contained in statutory financial statements and in many cases use the audit work papers of the company's independent auditor to supplement the examination of assets and liabilities.

When the examination team has completed the on-site work, information obtained on site is be compiled into a working draft report and distributed to key DOI staff and company executives. Company executives are given 30 days to identify factual errors or omissions in the draft report. Once any discrepancies are resolved, the Commissioner may either accept the report and issue it with an order for the company to comply with the recommendations or direct the examiners to readdress any deficiencies contained in the report.

The board of directors must sign affidavits acknowledging receipt of the examination report and the Commissioner's orders within 30 days of the receipt of the final report. The directors must respond with a plan to implement the report recommendations. Unless the examination revealed severe issues related to solvency, DOI does not follow up to verify compliance with the recommendations.

In situations where the examination reveals financial problems which could place policyholders at risk, the DOI may require continual monitoring, place the company under supervision, or place the company in receivership and liquidate the assets. Colorado has not had a significant number of companies with severe financial problems in recent years. Since 1990, only two Colorado domiciled companies were subject to corrective action resulting from a financial examination.

It is difficult, if not impossible, to identify a single reason for the relatively strong financial condition of Colorado insurance companies so far this decade. The strength of the industry is more likely a combination of factors. Improved economic conditions in the state definitely impact the insurance industry in a positive manner. Improved financial standards and increased scrutiny by the DOI also contribute to a stable insurance industry in the state.

A sample of financial examinations was reviewed as part of the Sunset Review process. The examinations were found to be complete, accurate, and thorough. Each examination contained a section evaluating recommendations from the previous examination that had not been implemented. The majority of these were minor technical violations of the regulations and did not present a significant risk to policyholders. However, it does give rise to concern about the effectiveness of voluntary compliance with the Commissioner's Orders.

Exceptions Found in Audits

I. TECHNICAL

These violations are not directly related to the financial condition of the company but are technical violations of statute or regulations. Examples:

- Reinsurance agreements which do not require 90-day notice of cancellation to the Commissioner.
- Agreements which refer to compliance with other states' statutes rather than Colorado's statutes.
- Failure to file fidelity bond with the Commissioner.

II. OPERATIONAL/MANAGERIAL

These issues relate to administrative details which may impact the corporate status of the entity or the admitted assets or liabilities of the entity. Examples:

- Failure to comply with corporate bylaws.
- Failure to have detailed written agreements with claims handling or underwriting contractors.
- Inadequate record protection procedures.
- Complaint files incomplete or nonexistent.
- Compliance of rates and forms to Colorado regulations.
- Inaccurate or misleading marketing information.

III. FINANCIAL

These issues directly relate to the financial security of the insurance entity. Examples:

- Failure to have a proper bond (letter of credit, deposit) with an authorized insurer or financial institution.
- Improper classification and statutory valuation of assets or liabilities.
- Failure to maintain adequate reserves.
- Failure to obtain an independent audit.
- Improper claims payment procedures, ineffective internal audit procedures.
- Using unauthorized reinsurance companies.
- Improper investment allocations.

In addition to conducting financial examinations of domiciled companies, the Financial Affairs unit reviews examinations of Colorado Authorized insurers conducted by other state regulators and reviews the annual financial statements filed by insurance companies. When a company authorized to conduct business in Colorado is identified as having solvency issues by its state of domicile, a tracking file is started in the Troubled Company Monitoring section. This section serves as a clearinghouse for Colorado policyholders for information about the company's status.

When a foreign company is placed on the troubled company list, the Commissioner has several formal and informal regulatory options. In extreme situations, the Commissioner may initiate action to seize the Colorado assets of a foreign insurer. A more common action may be to request the company refrain from writing new policies in the state until the company's financial status improves.

Financial examinations frequently reveal violations of standards established by the General Assembly to protect the public. These violations frequently go uncorrected for years, despite orders from the Commissioner to correct the problems. The only corrective action available to the Commissioner is direct action against the license of the insurance company, which is too extreme for most of the infractions. Requiring the offending company to submit a plan to correct violations and imposing fines for noncompliance would result in fewer violations carrying over from one exam to the next.

Recommendation #9: Give Authority to Commissioner to Set Underwriting Standards by Regulation for Homeowner, Dwelling Fire and Mobile Home Insurance

The Commissioner of the Division of Insurance should be given legislative authority to set underwriting standards by regulation for homeowners, dwelling fire, and mobile home insurance policies. Underwriting standards would include refusal to write, cancellation, nonrenewal, increase in premium, or reduction in coverage at the time of renewal.

Summary: Over the last year, the Division has received numerous complaints related to homeowner policies being canceled or denied, or having rates increased. Additionally, there is concern in certain communities that a single homeowner claim will result in cancellation of a policy. Lack of any regulation in this area leads to arbitrary practices by insurers and abuses against consumers. For these reasons, this report recommends that the Commissioner of the Division of Insurance be given authority to set underwriting standards in this area.

Discussion: Under the current statute, the Commissioner of Insurance has many inconsistent powers and duties that vary depending on the lines of insurance. The statutes regulating property and casualty insurance provide authority to the Commissioner to regulate cancellation and denial of auto insurance to consumers as well as increases in auto insurance premium costs. The limited regulations imposed against auto insurers from this authority have prevented and corrected many abuses in the market.

Over the last year, the Division has received numerous complaints related to homeowner policies being canceled, denied, or having their rates increased. An example of a typical complaint is the homeowner who has two small claims on their policy within two consecutive years and then has their policy canceled, not renewed, or rates increased dramatically by the insurer. In many other situations, homeowners are afraid to make any claim for fear of cancellation of the policy, and some insurers will not provide insurance to consumers who have claims made in the last two years against their old policies. Some communities are concerned that they are targets of such practices. Under the current statutory authority given to the Commissioner, there is little that can be done to prevent this from occurring except to sponsor legislation to correct these problems. The lack of any regulation in this area leads to arbitrary practices by insurers and abuses against consumers.

The DOI reports it received 93 complaints last year related to nonrenewal or cancellation of homeowner policies. This comprises 24 percent of all homeowner complaints received by DOI last year. Since July, DOI began reporting telephone inquiries related to homeowner insurance cancellations and nonrenewals. Between July and September 1996, DOI received 65 telephone inquiries concerning these issues. Extrapolated over a whole year, DOI will receive 260 inquiries by next July. Telephone inquiries may reveal the true breadth of the problem in this underwriting area. When addressing a consumer inquiry, DOI will explain its lack of authority in these matters. This may discourage consumers from following up the inquiry with a formal complaint letter because of the DOI's inability to address the complaint.

The Division is also aware that certain communities are concerned that these practices may be targeting their communities. For these reasons it is necessary for the Commissioner of Insurance to have at least the same authority to regulate homeowner insurers as the Commissioner has with automobile insurers.

Unlike other insurance lines, there is no large nonstandard market for homeowner insurance. For example, if an individual is denied auto insurance by one company because they have had too many claims, the individual may purchase insurance from another company that sells specifically to higher-risk individuals. The same applies in health insurance. Yet, in homeowner insurance, no such market exists. Once an individual has homeowner insurance canceled, chances are great that he or she will not be able to find any other insurer to provide coverage.

Alternative Recommendation #9: This report alternately recommends that the Commissioner of the Division of Insurance be given legislative authority to set underwriting standards by regulation for property and casualty, health, life, and disability insurance lines. Underwriting standards would include refusal to write, cancellation, nonrenewal, increase in premium, or reduction in coverage at the time of renewal

The general purpose of underwriting regulations like those in auto insurance is to prevent discrimination against consumers. Increasing the Commissioner's authority to set underwriting standards would elevate the Commissioner's powers in the auto insurance and health fields as well as provide equal and uniform powers to regulate all other types of lines. This proactive measure would allow the Commissioner to quickly react to any new underwriting practice concerns through rule-making procedures. Currently, at the earliest, abuses could not be addressed until the next legislative session. By the time a bill is enacted, harm will have already occurred. Such a proposal still safeguards the interests of all parties by requiring procedural guidelines of the administrative hearing process and expedites the Division's ability to take appropriate action on problems that occur in this area.

The enactment of this proposal would allow the Commissioner to address certain recommendations made in this report through the rule-making process. Specifically, the issues of domestic abuse and credit history would not require legislative action.

Recommendation #10: Transfer Automobile Self-Insurance Certificate Issuance Responsibility to Commissioner of Insurance - Authorize the Commissioner to Adopt Standards for Fleet Self-Insurers

Summary: The Department of Revenue (DOR) has no expertise in administering an insurance program. Complaints about unpaid claims are not tracked, and statistics on the disposition of complaints are not available. DOR has not promulgated regulations for the issuance of a certificate of self-insurance. Consumers with concerns about unpaid claims should have a single point of contact and a standard process for complaints.

There are approximately 41 self-insured fleets in Colorado. Each fleet is required to submit an application for a self-insurance certificate containing audited financial statements, two-year claims history, and a list of registered motor vehicles. There are no requirements for stop loss insurance, bonding, or loss reserves. The DOR has no ability to compel a self-insured to pay a claim and no ability to issue a fine for noncompliance with no-fault insurance statutes. In the event a self-insured fails to pay a claim or violates the statute, DOR may revoke a certificate of self-insurance.

Recommendation #11: Change the Loss Threshold Limit in Auto Insurance to a Verbal Threshold

Change the loss threshold limit for lawsuits to recover noneconomic damages from $2500 in medical expenses to a verbal threshold similar to that used in Michigan.

Summary: The current threshold limit for liability suits is extremely low in comparison to the benefit limits mandated by Colorado's no-fault insurance law. This results in an excessive number of suits, driving up insurance rates. Verbal thresholds in other states have been successful in reducing suits and lowering premiums, without significantly reducing medical benefits to consumers.

Discussion: Automobile insurance affects most citizens of Colorado in one way or another. Colorado adopted a mandatory financial responsibility law in 1963. In 1974, Colorado implemented a mandatory, modified no-fault insurance law. Colorado law requires that any defined motor vehicle operated on a public highway or street be covered with minimum property damage, personal injury, and personal liability insurance. Proof of coverage is required to be in the possession of the operator of the motor vehicle. Owners of 25 or more registered motor vehicles may apply with the Director of the Department of Revenue for a certificate of self-insurance under the provisions of §10-4-719, C.R.S.

Individuals having difficulties resolving claims with insurance companies may file a complaint with the DOI Consumer Affairs unit. Representatives in the Consumer Affairs unit educate consumers as to their rights under Colorado's no-fault law and attempt to mediate disputes between consumers and insurers.

Owners of fleets self-insured under §10-4-719, C.R.S., are not subject to financial reviews by DOI under the provisions of §10-1-201, C.R.S. *et seq.* At the time this report was prepared, the Director of the Department of Revenue was considering promulgating formal standards, financial requirements, and reserve requirements for obtaining a certificate of self-insurance. Individuals with difficulties resolving claims with self- insured drivers do not have the ability to file complaints with the DOI. The Department of Revenue does not maintain a tracking system for consumer complaints related to self-insured fleets.

Mandatory coverage for personal passenger automobile policies issued in Colorado are contained in §10-4-706, C.R.S. Mandatory coverage limits are the minimum coverage that all personal passenger automobile insurance policies sold in Colorado must contain. Self-insured fleets must comply with the same benefit limits. A basic overview of the mandatory coverage limits are:

Liability coverage for bodily injury:	$25,000/person $50,000/accident
Property damage:	$15,000
Personal injury protection:	
medical expenses	$50,000
rehabilitation expenses	$50,000
wage loss	up to $400/week
essential services	$25/day
death benefit	$1,000

In addition to the mandatory coverage, most insurance carriers offer additional coverage. Common additional coverage includes collision, comprehensive damages, uninsured motorist, and roadside service.

Colorado is a file and use state for automobile insurance premium rates. This means that insurance companies are not required to obtain approval for insurance rates prior to using them for new policies or policy renewals. Premium rates and most underwriting policies are at the discretion of the individual insurance carrier with the provision that they must comply with the general rate guidelines which prohibit rates from being excessive, inadequate or unfairly discriminatory. The Rates and Forms Section of DOI annually reviews the rate filings for insurance companies covering 80 percent of the personal passenger automobiles insured by private insurance in the state.

As with all insurance rates, companies use a variety of criteria to establish auto premiums: the type of vehicle driven, the age and experience of the driver, loss experience of the driver, the type of driving being done, and the loss experience of the insurance carrier. Insurance carriers offer a variety of discounts and incentives to lower premiums for “good risks.” The types of discounts vary, but some include good driver discounts, good student discounts, multiple vehicle discounts, and homeowner discounts.

The insurance statutes contain restrictions on when an insurance carrier may discontinue coverage or increase premiums for automobile coverage. Consumers who believe they have had coverage changes or unjustified premium increases may appeal to the DOI for relief. The Property & Casualty Section of the DOI consumer affairs reviews complaints and mediates disputes between consumers and insurance companies on this issue.

Consumers have the option of requesting a formal hearing for relief in situations involving nonrenewal, premium increases, and coverage changes. The procedures for these appeals are contained in the Colorado Code of Regulations (CCR) 5-2-3. Approximately 69 percent of the consumer appeals that go to hearing are upheld by administrators hearing the complaint. Insurance companies prevail in over 60 percent of all protests filed. The Insurance Protests table details automobile insurance appeals for the last three years.

Insurance Protests
Personal Passenger Auto

YEAR	*1993*	*1994*	*1995*	*TOTAL/%*
Protest requests	2329	2335	2067	6731/100%
Dismissed	1319/56%	1452/62%	1192/58%	3963/59%
Insured drops protest	38/2%	44/2%	51/2%	133/2%
Company rescinds action	541/23%	494/21%	506/24%	1541/23%
Hearing held	431/19%	345/15%	318/15%	1094/16%

Protest Hearing Results

YEAR	*1993*	*1994*	*1995*	*TOTAL/%*
Hearings	431	345	318	1094/100%
Company upheld	110/26%	111/32%	117/37%	338/31%
Insured upheld	321/74%	234/68%	201/63%	756/69%

Most states have provisions for mandatory insurance coverage for automobiles. There are two basic models for mandatory automobile coverage. The traditional, or tort, model requires coverage, but requires victims in accidents involving automobiles to prove blame, or fault, before collecting benefits from an insurance carrier. The second model in automobile coverage is no-fault laws. These laws allow for prompt payment of claims without the costly and time-consuming delays common in tort states.

A pure no-fault statute would require insurance carriers to pay claims on behalf of their insured without questioning fault or cost. Benefit limits would be scheduled in statute and accident victims would not be allowed to sue for additional damages. No state has adopted a true no-fault law. However, the Michigan no-fault statute is considered to be the closest to a true no-fault scenario.

The Colorado statute is considered a modified no-fault law. Under the Colorado statute, persons injured in an automobile accident may recover non-economic damages (pain and suffering) only after the medical expenses exceed $2500. The damage threshold in Colorado is one of the lowest in the nation in comparison to the mandatory benefits. Industry representatives maintain this leads to an excessive number of lawsuits in the state.

Premium Rates

Virtually every person in Colorado is affected by automobile insurance. A significant portion of the state population purchases insurance for their personal automobile. A major concern of automobile owners is the cost of automobile insurance. In the most recent data available, Colorado was ranked the 13th most expensive state in which to purchase private passenger automobile insurance.

Automobile insurance comprises of three major components: Collision (coverage to repair or replace your vehicle in the event of an accident), Comprehensive (coverage to repair or replace a vehicle in the event of damage not related to an automobile accident, such as theft or glass breakage), and Liability Coverage (the minimum mandatory coverage).

Collision insurance covers the owner of the automobile for damages up to the replacement cost of the car. Some policies cover the expense of a rental car while the damaged auto is being repaired. According to the NAIC, the average cost for collision insurance in Colorado in 1994 was $184/year, or the 31st most expensive state. This represents a 12 percent increase over the 1989 premium of $164 when Colorado was ranked 36th in collision premium expense.

Part of the increase in premiums relative to other states can be attributed to the improved economic conditions in the state. As a general rule, insurance producers recommend eliminating collision coverage or increasing deductibles on older, less valuable vehicles. Therefore, consumers are less likely to have insurance claims with an older automobile, which in effect holds down rates. A robust economy, on the other hand, increases new vehicle sales, which in turn increases the likelihood a vehicle involved in an accident will be covered or have a lower deductible. This acts to increase claims paid, which results in overall higher premiums.

Comprehensive insurance covers vehicles from losses not related to an automobile accident. Events such as theft, vandalism, windshield damage from gravel, and weather-related damage are covered under this portion of an automobile policy. Colorado has consistently ranked in the top ten for average comprehensive premiums for the past several years.

A significant factor in the high comprehensive premium fees are weather-related claims, specifically hail damage. Colorado has more hail related claims than most states. Another weather-related claim that has increased recently is windshield damage. Windshield claims are directly related to street sanding episodes in the metro area. At least a portion of this can be attributed to the use of larger, harder street sanding material. The move to this type of material in the metro area was prompted by efforts to improve air quality in the region.

The most alarming trend in automobile premiums in Colorado is the rapid increase in liability insurance. The average premium in Colorado has increased 50 percent, from $317 in 1989 to $476 in 1994. This increase is almost double the national average of approximately 28 percent. Colorado was ranked the 15th most expensive state for liability premiums in 1994, and 10th in the nation for percentage increase over 1990 premiums.

Sources contacted for this report voiced a variety of opinions for the increase in liability premiums in Colorado. These sources included industry representatives, regulators, and consumer advocates. While all expressed concern over the premium increases, there was disagreement as to the causes and solutions of the problem.

Explanations given for the increased premium include consumer fraud, excessive or unnecessary litigation, uninsured motorists, spiraling medical costs, unnecessary medical procedures, excessive regulations, lack of regulatory enforcement, and price gouging. As with any complex issue, simple solutions are not obvious.

According to the U.S. Bureau of Labor, the National Consumer Price Index increased an average of 3.6 percent/yr. from 1989 to 1994. The total medical care index increased at double that rate, or 7.2 percent for the same period. NAIC reported an average annual liability premium increase of 4.3 percent from 1989 to 1994. Since medical expenses have a large impact on liability claims, it follows that a portion of the excessive increase in Colorado should be attributed to medical costs. However, even if the medical expense increase was directly correlated to liability premiums, an insupportable assumption, the adjustment does not justify the premium increase in Colorado.

To address increasing premiums due to rapidly rising liability expenses, the General Assembly passed several measures in recent years: Personnel Injury Protection (PIP) cost containment, low-income insurance option, and optional wage loss coverage. The PIP cost containment allows insurance providers to offer discounted PIP coverage to insureds who agreed to use medical services of a HMO or PPO selected by the insurance company. According to a DOI survey, discounts for drivers participating in these programs range from $23 to $129 per year.

Proponents of the option claim that PPOs contracting with insurance companies reduce medical costs and reduce the time injured drivers require medical treatment. Critics claim that managed care plans restrict the injured parties right to litigate and provide lower-quality medical care. There is no independent data to support the position of critics. Since the plan is offered as an option, it is up to the individual consumer to determine if the cost savings are worth a reduction in medical care choices.

The low-income PIP option was an attempt to address the uninsured motorist issue by offering lower PIP coverages to households with annual incomes under $20,000 per year. Insurance carriers offering this product are required to discount the premium 20 percent from standard policies. Few insurance companies offer this option because the 20 percent discount is not justified by the reduction in coverage.

A portion of the mandatory minimum automobile insurance coverage is for lost wages. Retired and unemployed individuals do not have lost wages to be replaced. Therefore, paying insurance premiums for a benefit they have no chance to collect on does not make economic sense. In an effort to reduce insurance premiums for retired and unemployed individuals, the General Assembly made wage loss coverage optional for individuals who can provide documentation proving a lack of earned income. Utilization of this option has been more successful than the low-income option.

The Coalition Against Insurance Fraud (CAIF), a Washington D.C.-based group representing advocacy organizations, insurance companies, and regulators, estimated auto insurance fraud in Colorado costs consumers $220 million. This figure was arrived at by using the National Insurance Crime Bureau estimate of 16.44 percent of claims and adjusted by using a factor provided by the Insurance Research Council for regional fraud tolerance. This figure includes collision and comprehensive fraud, as well as liability fraud.

Automobile insurance fraud can be perpetrated by individuals overstating losses, autobody shops padding bills, or health care professionals overtreating injuries. Detection and investigation of fraud by individuals is usually the responsibility of the insurance carrier. Criminal prosecutions are extremely rare.

Organized rings have operated involving lawyers, healthcare providers, and entire families, faking accidents and injuries to obtain large settlements from insurance companies. Investigation of organized rings can be joint operations of law enforcement agencies, insurance companies, and insurance regulators. Insurance companies advocate increased activity by law enforcement and regulatory authorities in this arena. It appears that current laws are adequate to address insurance fraud. However, investigations seldom result in prosecutions. Fraud cases are complex, take a great deal of expertise and resources, and are difficult to prosecute.

A few industry sources expressed an opinion that the auto insurance appeals process forced companies to continue to insure drivers at an inappropriately low rate. When claims against a driver classified at a preferred category are paid, it results in a higher loss experience for the entire class of drivers. An increased loss experience can result in higher premiums for the entire category of drivers. However, the appeals process was created to prevent companies from unjustly reclassifying, canceling, or changing coverage for drivers. Since consumers are upheld on over 30 percent of the appeals, it appears the process is necessary to protect consumers.

When an insured motorist is in an at-fault accident, his or her insurance company pays the insurance claim, then may adjust the individual’s rates, based on claims experience. Drivers with poor driving records are more likely to be involved in at-fault accidents and are therefore charged more for insurance coverage. When a driver without insurance causes an accident, claims are paid by the insurance companies of good drivers, and premiums are increased across the board for all drivers in that class.

Estimates of the number and impact of uninsured motorists vary. DOI estimates range from 20-25 percent of all motor vehicles in the state that are operating without insurance. In 1994, the City of Aurora conducted an insurance check point stop where all cars on a given point were checked for proof of insurance. According to data resulting from this survey, 11.5 percent of the vehicles in Aurora do not have insurance coverage. However, this sample is too small and localized to be applied statewide. Industry sources indicate that based on the frequency and severity of claims related to uninsured motorists, the impact on total premiums is approximately 10-15 percent.

Alternatives

Insurance premiums are primarily based on three factors: administrative expenses, frequency of claims, and severity of claims payments. Advocates for insurance reform have recommendations to reduce the impact of each factor.

The severity of claims payments is expressed in terms of dollars paid out. If dollars paid on claims can be reduced, premiums would naturally decrease, or at least the rate of increase decline. Eliminating fraud and uninsured motorist would reduce the severity of claims. Reducing maximum benefits would also impact claim dollars.

The focus of fraud investigations by DOI is from a direct consumer protection standpoint. That is to say, DOI investigates fraudulent activities of insurance producers and companies, including unauthorized companies selling insurance. DOI staff cooperate with insurance company and local law enforcement officials investigating fraud by consumers; however, they do not initiate or lead investigations of this type.

Uninsured motorist statutes are monitored and enforced by a combination of local and state regulatory and law enforcement authorities. Vehicle owners are required to sign a statement that they have automobile insurance when they register a vehicle with their county clerk. State police, county sheriffs, and city police require vehicles stopped for any traffic violation to show proof of insurance. It would not be practical for DOI to perform this function.

Technology is available today to track insurance information on registered vehicles by computer. This would involve requiring insurance carriers to report electronically whenever a policy is issued, renewed, or canceled. Law enforcement and vehicle registration officials could use this information to aggressively enforce the mandatory insurance law. A system such as this may be expensive; however, it is likely a cost benefit analysis would justify devoting resources in this area.

The state of Utah adopted an uninsured motorist database system in 1994. Insurance companies submit information to a private vendor on in-force private passenger insurance policies monthly. This information is matched against vehicle registration information from the state motor vehicle database. Law enforcement officials have access to insurance information using existing motor vehicle registration information while in the field, either by radio contact with police dispatchers or by computer. Utah reports a 20 percent reduction in the number of uninsured motorists since the introduction of the program.

Medical liability coverage for bodily injury (coverage to people in the “other” vehicle) in Colorado is mandated at $25,000 per person, $50,000 per accident. Personal injury protection (coverage for people in your car) is set at $50,000 for medical and an additional $50,000 for rehabilitation. Advocates of lower limits to reduce premium costs argue that Colorado is in the top 10 percent for mandatory liability coverage. This assertion is somewhat skewed because of the fact some states do not have mandatory coverage, and several states have identical minimum standards.

Information from the Insurance Service Office, Fast Track Data, indicates that liability claims in Colorado average under $20,000 per accident. A recent study by the Rand Corporation found that nationally, 96 percent of the individuals in automobile accidents have medical expenses under $10,000. The same Rand study indicated that 1 percent of the individuals injured in auto accidents incur medical expenses in excess of $250,000. Given this information, it could be argued that the mandatory limits in Colorado are excessive. However, information on the distribution of injury expenses was not available, so that conclusion is not defensible. Given the information available, the mandatory limits in Colorado appear to be sufficient to protect the public.

What is true is that Colorado has a relatively low threshold for law suits to collect noneconomic damages. A true no-fault system would not provide for legal action to recover damages. In practice, all no-fault states allow suits when specific criteria are met. The stricter the standard, the fewer the number of suits. Legal actions serve to increase costs to insurance companies, these costs are passed on to consumers in the form of higher premiums. States with high monetary, or strict verbal thresholds, have fewer legal actions to recover damages.

Studies by the Rand Corporation have shown states with generous liability limits, combined with high monetary, or strict verbal thresholds, for suits, have higher actual medical payouts to injured parties, without increasing premium expenses. For example, Michigan has what many consider to be the closest to a true no-fault statute. There is no maximum medical benefit allowed under the Michigan no-fault law. That is to say, if you are injured in an accident, all reasonable medical expenses will be paid. However, Michigan has a strict verbal threshold for the initiation of legal action to collect noneconomic damages. Suits are permitted in cases involving death; serious impairment of bodily function; and permanent, serious disfigurement. Michigan ranked 25 in liability premium expense in 1993, compared to 15 for Colorado.

PAP

An alternative that addresses several cost factors is the Pay-at-the-Pump (PAP) concept. In a PAP scenario, motorists would pay a surcharge for each gallon of gas purchased. The surcharge would be deposited into a fund to pay automobile-related claims. The system could be privatized, with the state "passing through" funds to insurance companies. High-risk and alternative fuel vehicles could be charged an additional registration fee, and drivers with poor records would be addressed by increasing fines for traffic violations.

This system would eliminate uninsured motorists, since gasoline is purchased by all drivers. Administrative expenses of insurance companies would be reduced, since sales and marketing costs are a major component of the administrative expense portion of insurance premium. Advocates of PAP even maintain that if PAP were combined with changes in coverages, fraud would be greatly reduced.

Pay-at-the-Pump legislation has been considered by the General Assembly in the past. An analysis of PAP literature and proposed legislation demonstrate the concept is feasible and could reduce overall insurance costs. However, even the most ardent supporters agree Colorado is not an ideal state to pilot this type of program, unless it is in conjunction with several surrounding states. States with a minimum population with access to border states, such as Hawaii and Florida, are less likely to have problems with drivers purchasing cheaper gas at border service stations.

Recommendation #12: Require Workers' Compensation Self-Insureds to Report Closed Claim Information to DOI

Summary: Information on the disposition of WC claims is vital to the General Assembly to evaluate the benefits injured workers are receiving as well as the cost to employers. Prior to January 1996, all WC self-insured plans and WC carriers were required to report this information to the DOI to be included in an annual report to the General Assembly. Beginning on July 1, 1996, self-insured employers were exempted from the reporting requirements. Since self-insured employers are among the largest employers in the state, any report prepared by the DOI will be lacking in a significant amount of data. (See Discussion commencing on page 113.)

Recommendation #13: Require CCIA to Follow the Same Marketing Practices as Private Workers' Compensation Carriers

Summary: In its original incarnation, the Colorado Compensation Insurance Authority (CCIA) was an insurer of last resort, and operated as a governmental agency. When CCIA was privatized in the 1980s, it retained some marketing privileges, such as the ability to set premiums below the market rate without the prior approval of the Commissioner, that private carriers do not enjoy. CCIA is becoming more aggressive in marketing its product to traditional, established employers, which is necessary to maintain its financial solvency. However, allowing CCIA an unfair competitive advantage may result in unintended financial consequences in the future.

Recommendation #14: Expand Authority of Commissioner Over CCIA

Summary: The Commissioner is required to conduct financial examinations of CCIA every three years, as opposed to every five years for private WC companies. However, the Commissioner does not have the ability to order CCIA to comply with financial solvency requirements. The Commissioner's report is presented to the Governor, who may replace members of the CCIA Board of Directors.

***Discussion*:** Employees of most entities in Colorado are required to be covered by some form of Workers' Compensation (WC) insurance. Oversight of the WC system in Colorado is divided between the DOI and the Division of Workers' Compensation in the Department of Labor and Employment. WC consists of two components: medical treatment, and lost wages. Essentially, WC indemnifies employers from costly law suits by injured workers in return for agreeing to compensate the employees for medical expenses and lost wages.

WC rates are established by a fairly complex system. Rates are made up of two major components: the loss costs and the expense multiplier The loss costs are filed with the Commissioner annually and are subject to approval by the Commissioner prior to use. They consist of actual losses, loss adjustment expenses, and loss trend factors. The loss costs are filed by a national rating organization, the National Council on Compensation Insurance (NCCI), for all of its member companies. Essentially, most WC companies are members of NCCI and use their filing.

The expense multiplier is filed by the individual insurance company to take into account the company's individual expense experience. This factor consists of production expenses; general expenses; licenses, fees, and taxes; profits and contingencies; and assessments. This factor allows companies with more efficient operations, or lower expenses, to use a lower multiplier, resulting in more favorable rates for the consumers (in this case, employers).

Essentially, every employer is categorized into one of five employer classifications: Service, Manufacturing, Construction, Clerical and Other. In addition, individual jobs are assigned 1 of over 600 job classifications. Each classification is assigned a standard rate by an insurance rating organization. Insurance carriers may use their multiplier against the loss/cost rate to arrive at a basic WC rate per $100 of payroll and ultimately, the premium for the individual employer. Employers with limited history, or experience, are assigned this rate, known as a standard or basic rate. Qualifying employers with three years of claims history use a rating modifier based on individual claims history. This is known as an experience rating.

The NCCI recommends loss/cost rates for WC insurance annually. The loss/cost rates are based on overall loss experience by classification. Once the loss/cost rates and job classifications have been approved by the Commissioner, all WC carriers may use the same loss/cost rates. Individual insurance companies may file for a different loss/cost.

Carriers are allowed to modify loss/cost rates by adjusting the expense multiplier. This adjusted multiplier is filed with the DOI and must be supported by actuarially sound statistics. This is a common method used by insurance companies to provide favorable rates to employers.

All employers are eligible for rates modifications by having an approved safety program in place. For small employers, discounts range from 2 to 10 percent based on the individual loss experience and other statutory factors. Employers subject to experience modification may receive discounts of up to 30 percent for safety programs in place, among other factors, which show that the employer is entitled to better than a standard rate. Safety programs are approved by the Cost Containment Board and must be in place for one year in order to be eligible for discounts.

Each of the WC components can be very complex, and how individual employers treat WC injuries and claims has a significant impact on individual rates. For example, some employers are very aggressive in returning injured employees to work, even at a “light duty” assignment, to reduce lost wages. Other employers do not want employees to return until an independent medical examination has been completed and maximum medical improvement has been achieved. This not only drives up the lost wages, but also increases the medical expenses.

During the 1980s premiums for WC in Colorado significantly increased. Some businesses cited excessive employee expenses as one factor for relocation out of Colorado.

In 1991 the General Assembly passed SB 91-218 which substantially reformed WC in Colorado. SB 91-218 created the Division of Workers’ Compensation (Division) in the Department of Labor and Employment (DOLE). Among the oversight responsibilities granted the Division are: claims handling, impairment rating, enforcement of mandatory insurance requirements, implementation of a safety certification program, and permitting employer self-insurance plans.

DOI retained regulatory oversight for private WC insurance companies, governmental self-insurance pools, and professional or trade association self-insurance pools. Changes in WC insurance rates are considered annually by the Commissioner of the Division of Insurance.

The largest WC insurer in the state is the Colorado Compensation Insurance Authority (CCIA), with over 50 percent of the market share. The forerunner of CCIA, the State Compensation Insurance Fund, was established in 1915. CCIA concentrates on the residual market; which are those employers most private carriers would not underwrite. CCIA can require businesses to pay a premium deposit up-front to offset the risk associated with underwriting higher-risk employers.

Unlike private insurance companies, CCIA does not pay premium taxes to the DOI. However, it does pay fees based on premiums to the Division to cash fund Division activities. Self-insured employers are permitted by the Division and also pay fees directly to the Division to cash fund regulatory oversight activities. All WC insurance companies pay some fees to the Division. These fees are factored into their individual expense multiplier as an assessment.

In recent years, CCIA has broadened its marketing base to compete with private insurance companies for "good risks." This diversification of risks is necessary to maintain financial solvency. CCIA has aggressively used independent agents statewide to market WC to a variety of employers. The commissions offered these agents are competitive with those offered by private carriers. Some private carriers have expressed concern that CCIA does not have to comply with the same regulatory requirements and therefore is able to offer rates below those the private market is able to justify.

Any insurance company may file a rate request with the Commissioner. Once sufficient documentation is obtained, the Commissioner may hold a hearing to approve a rate for an individual company. This process is very expensive, complex, and rarely used. Instead, insurance companies use the file and use process available to them to justify a lower rate multiplier. CCIA is allowed to use a premium rate below the rate established by the Commissioner without applying for approval. CCIA is allowed to use a special discount not available to private carriers. CCIA does not use this provision often; instead, it relies on the same rate multiplier process used by private carriers. However, the special discount, if abused, could lead to CCIA's underfunding risks.

The DOI is required to conduct financial examinations of CCIA substantially similar to those conducted on private insurance companies. However, because of the unique nature of CCIA, it does not have to comply with the same reserve and surplus requirements as a private carrier. Therefore, the Commissioner has no ability to order CCIA to comply with insurance financial regulations. Market conduct examinations are not conducted on CCIA other than those activities that would be reviewed as a part of the financial examination. The Division has the ability to review claims procedures of CCIA on a case-by-case basis. The Division does not have the ability to order CCIA to modify claims procedures.

The statutory authority for CCIA, and its regulatory oversight is split between Title 10 and Title 8 of the Colorado Revised Statutes. This leads to the potential for duplicative regulation, as well as lack of regulatory authority. CCIA serves a necessary function in the WC market. Without CCIA, Colorado would have to return to a state-operated insurer of last resort or establish some type of assigned risk pool for WC insurance. Neither of these options has support from employer groups or industry.

The Commissioner is required to examine CCIA every three years, but has no authority to order CCIA to implement changes based on the financial examination. While CCIA serves an important market, the last two financial examinations indicate concern over its financial stability. If the standards applied to a private carrier were to be applied to CCIA, it would not only be in violation of Colorado financial requirements, it could possibly be declared insolvent.

The Governor can, and has, made changes in the Board of Directors of CCIA to bring about changes to operations. Implementing changes this way is very time-consuming and inefficient. CCIA does need some degree of flexibility due to its unique market niche. Aggressive marketing and increased sales of CCIA give rise to concerns about its continued ability to meet financial obligations. Increasing the regulatory role of the Commissioner is a prudent step to provide protection to the public from a potentially large financial obligation.

The DOI conducts regular reviews of self-insurance pools to evaluate the actuarial soundness of reserves, claims handling procedures, and loss ratios. The Division conducts regular examinations of self-insured employers to evaluate actuarial soundness of reserves, claims handling procedures, and loss ratios. Both the Division and DOI rely on independent audits supplied by the self-insured entities in between formal reviews.

A 1995 report by the State Auditor found inadequacies in the financial examinations by the Division of Workers' Compensation of self-insured employers. The audit report also identified concerns with the collection of fees by the Division of Workers' Compensation. The Division agreed with the audit findings and is working to address the problems identified. This involves the use of an actuary to evaluate the soundness of the reserves established by self-insured employers.

DOI has actuaries on staff that routinely evaluate actuarial information from all types of insurance companies and self-insured entities. The evaluation of actuarial information of self-insured entities is clearly an insurance function more appropriately conducted by the regulatory authority familiar with insurance issues. In Colorado, this is the DOI. Consolidating the permitting of self-insured employers into the DOI allows for economies of scale with respect to actuarial and financial reviews.

DOLE has the responsibility for enforcing the mandatory WC law and collecting premium assessments from WC carriers. These functions are not necessarily appropriate in the DOI. They are more analogous of the enforcement of mandatory automobile insurance by local law enforcement agencies. The DOI makes sure the insurance companies are solvent; other appropriate agencies ensure consumers comply with the laws designed to require financial responsibility.

A major factor in WC rates is job classification. Rates are based on multiples of $100 of payroll. Job classification rates range from .002/$100 of payroll for clerical staff to 100/$100 of payroll for some high-risk jobs such as roofers or steel workers.

Improper classifications can result in significant, inappropriate expenses to an employer. These unnecessary expenses could result in a business being placed at a competitive disadvantage and eventually going out of business. To prevent this from occurring, the DOI has in place a classification appeals process. This process allows employers who believe individual employees are misclassified an opportunity to submit evidence to an impartial referee.

Employers that believe they, or their employees, are misclassified may file an appeal with the DOI. An informal, nonbinding hearing is conducted by a panel selected by NCCI. If both parties agree to the decision of the panel, the complaint is resolved. If either party disagrees, an appeal may be filed with the Commissioner. In Fiscal Year 1995-96, the DOI heard 11 appeals and ruled in favor of the employer on 7, or 63 percent. These appeals resulted in premium refunds to employers in excess of $1 million. The process was modified substantially by HB 96-1057. However, at the time this report was completed, no complaints had been filed using the new procedure.

Under the provisions of SB 218, all insurance companies are required to provide data on closed WC claims to DOI. Until January 1996, all self-insureds were required to provide the same information. This data is used by DOI to produce a report to the General Assembly evaluating the effects of WC reform on premiums and benefits to employers.

There are approximately 130 self-insured employers permitted in Colorado. These are generally the largest employers in the state, employing approximately 20 percent of the employees covered under the WC Act. These employers represent a significant number of the state's employees and, consequently, a significant percentage of the state's injured workers. Exempting this population from inclusion in a report used to formulate public policy on an issue as important as WC severely compromises the ability of the General Assembly to evaluate all relevant information.

Recommendation #15: Eliminate Individual HMO Premium Filings - Change the Language Concerning HMO Rate Filings to Clarify That Only Rate Information Needs to be Filed

Summary: Under current law, any time an insurance company changes rates, the new rate must be filed, reviewed, and accepted by the DOI. Because the statute combines the terms rate and premium, HMOs and the DOI have interpreted this to mean any new agreement entered into by a HMO. This has resulted in unnecessary filings by HMOs and reviews by the DOI.

Discussion: Section 10-16-107, C.R.S., requires HMOs to file notices with the DOI whenever rates or premiums change. A rate is a factor used in calculating a premium; for example, geographic location (high-price vs. low-price areas), age, health status, smoker vs. nonsmoker, or occupation. Most lines of insurance file rates with the DOI under the file and use method and apply the rate factors to calculate premiums for individual policies. The premium is the final result of applying all rating factors to an individual or a group. HMOs are required to file rating information annually. This involves disclosing all information used to formulate premium rates. When individual contracts are negotiated, the factors on file are used to calculate the premium for the contract.

The effect of requiring HMOs to file premium changes with the DOI every time a rating factor changes for an individual or a group causes duplicative filings. It is analogous to requiring an automobile insurance company to file premium notices for each policyholder every time the policy is renewed. As long as the rating factors on file are not deviated from, it is a simple calculation to determine the premium for an individual contract. Requiring HMOs to file contracts just because a premium has changed results in unnecessary and duplicative paperwork for both the DOI and the HMO. Clarifying the filing requirements in statute would eliminate approximately 196 unnecessary filings annually.

Recommendation #16: Change HMO Financial Examination Cycle to Every Five Years

Summary and Discussion: HMOs are currently examined every three years. Other types of insurance companies are examined every five years. This review found no additional public protection afforded by the more frequent examination schedule for HMOs. To be consistent, all insurance companies should be reviewed on the same schedule. The Commissioner has the ability to examine any company more frequently if there is reason to believe more frequent examinations are necessary.

Recommendation #17: Repeal Provision Which Allows Insurers to Use Credit History as an Underwriting Criterion

This report recommends the repeal of §12-14.3-103(C)(III), C.R.S., which specifically allows insurers to use credit history as an underwriting criterion. Additionally, the Division of Insurance should review the viability of credit history criteria and develop model legislation to address any negative issues related to this practice.

Summary: The use of a consumer's credit history in insurance to evaluate the insurability of the applicant raises public policy questions of whether this practice results in unfair discrimination from insurance underwriting. Regulators, legislators, and consumer activists fear that the use of credit reports may disproportionately affect the poor. Some feel that the use of credit reports could be used as a redlining tool. Currently, 11 states restrict the use of credit reports in insurance underwriting. Most of these prohibitions relate to its use in auto insurance underwriting or rating. While many other states have proposed legislation to restrict the use of credit history, Colorado has gone in the opposite direction. According to the NAIC, Colorado is the only state that has statutory language which allows credit history to be used in insurance underwriting.

The growing trend of insurers using the credit history of individual policy holders for underwriting purposes has created considerable debate about its scope and appropriateness. Much of the debate of the use of credit reports revolves around whether and how they should be used by insurers in different insurance lines. Insurers believe that there is a direct relationship between the financial stability of the policyholder and the risk to the insurer.

Credit history is used by insurers in many lines of insurance underwriting. The Health Insurance Association of America (HIAA) states that credit reports are generally not used in major medical markets for either group or individual coverages. Life and health insurance do not use credit reports of the type that are used to establish a person's eligibility for credit but rather use a more comprehensive report called an "inspection report" to evaluate the insurability of the applicant. The inspection report contains information on smoking, alcohol and drug use, driving record, occupation, criminal record, and other aspects of the individual. Life insurers typically will use inspection reports based upon the amount of insurance applied for by the applicant.

Property and casualty insurers of commercial lines have used credit reports for many years as a tool for their underwriting practices. Commercial insurance risks often include a greater amount of credit risk than personal insurance exposure. Because of the large amount of money involved in commercial property and the increased risk to the insurer if damage should occur, credit reports are a good tool to determine the financial health of the company prior to writing the policy. Commercial insurers claim that there is a strong relationship between credit reports and loss experience. For example, credit problems can reliably predict the erosion of machinery maintenance, safety programs, and compliance with the Occupational Safety Health and Safety Administration (OSHA) standards.

Property and casualty insurers of personal lines use credit history as an underwriting tool, but practice differs among insurers as to how credit information is evaluated and its relative weight among underwriting information.

Some companies such as Allstate Corporation contend that a person's credit history is a very good tool to predicting future claims on auto policies. An exam of the credit backgrounds of 60,000 Allstate auto insurance customers and their claims indicated that policyholders with poor credit histories cost Allstate 40 percent more than those with good credit histories.[17] Additionally, Fair, Isaac, & Co., a data analysis company, has developed statistical models which predict the likelihood of an insured loss based upon credit history. However, questions remain as to the methodology used in the study, as well as the conclusions drawn.

Other companies including Allstate use credit history as a tool in underwriting homeowner's policies. Despite industry's confidence in the relationship between credit history and risk of loss, the issue remains controversial.

The main controversy of this practice is whether it results in unfair discrimination from insurance underwriting. Underwriting of insurance policies looks at certain characteristics of the consumer or property which is used to determine whether the insurer will write the policy or what rate they will charge. Certain underwriting factors, regardless of their relationship to risk and loss, are considered unfair and are prohibited from use. Every state prohibits the use of race, national origin, and religion as an underwriting or rating factor. Additionally, Colorado prohibits classification differences between neighborhoods within the same municipality, genetic testing, and sexual orientation classifications as underwriting criteria.

[17] Wall Street Journal, 11/6/95.

Regulators, legislators, and consumer activists fear that the use of credit reports may disproportionately affect the poor and especially minorities who tend to earn less than non-minorities. Some feel that the use of credit reports could be used as a redlining tool that enables insurers the ability to not write insurance for certain classes and ethnic backgrounds.

DORA conducted a survey of insurers in the state to determine if credit history was an underwriting and rating criteria and how this information was used by insurers. Of the 320 insurance companies surveyed, 175 answered the survey. Of that number, approximately 40 percent of those companies stated that they used credit history as an underwriting or rating factor. Although the use of credit history differs, it is evident that the practice is prevalent in Colorado. A 1995 survey conducted by the NAIC reported that ten states provide restrictions on the use of credit reporting. Most of these restrictions relate to the use of credit reports for auto insurance underwriting or rating. Since then, Massachusetts has also enacted legislation.

States Enacting Credit Reporting Restrictions

Arkansas	New York
Hawaii	Oregon
Louisiana	Texas
Maine	Virginia
Massachusetts	Washington
Montana	

Between 1993 and 1996, 19 states have proposed legislation restricting the use of credit history, with each year more and more states providing bills in their legislature.

While many states are enacting legislation to prohibit use of credit insurance under certain lines of insurance underwriting, Colorado has gone in a different direction. The Colorado Consumer Credit Reporting Act implicitly sanctions insurers to use credit history in connection with underwriting insurance involving the consumer. Enacted in 1995, the Colorado Consumer Credit Reporting Act identified restriction and uses of credit reports on consumers. That act, §12-14.3-103(C)(III), C.R.S., allows a credit reporting agency to provide a report to an insurer for underwriting purposes.

The NAIC has currently formed a committee to look at this issue and hopes to have model legislation by the end of the year. The controversy surrounding, as well as the public policy implications in addressing, this issue suggest that Colorado should take a harder look at whether credit history is a viable and adequate underwriting criterion for all insurance lines. As such, this report recommends that the Division develop model legislation to address the use of credit history for the 1997 session of the General Assembly.

Recommendation #18: Give the Division Authority to Audit Premium Tax Returns Through Both the Current Procedure and Field Audits

Summary: §10-1-204(2), C.R.S., gives the Commissioner, or the Commissioner's representative, authority to review records of an insurance company. This cite is contained in the section giving the Commissioner authority to conduct financial and market conduct examinations. Some companies have argued this authorization does not extend to the review of premium tax records for the purpose of a tax audit. Placing specific authority in the statute providing for premium tax collections would clarify this issue.

***Discussion*:** Insurance companies are the only major for-profit industry that is exempt from state corporate income tax. Income generated by investments, such as interest and capital gains, is not subject to the same tax treatment as a private individual, a bank, or a restaurant. In addition, while income taxes are factored into the pricing for goods and services by other industries, insurance companies are allowed to figure the premium tax into premium rates when filing for approval, thereby passing the tax cost directly onto the consumer.

In 1995, the DOI collected $107 million in premium tax revenue from insurance companies licensed or authorized to do business in the state. This represents the third-largest contributor to the Colorado General Fund of state-generated revenue, behind income and sales taxes.

Premium tax revenues are the largest contribution to the state general fund not collected by an agency established to collect and verify tax revenues. As previously mentioned, the DOI's mission is a combination of insurance promotion and consumer protection. It is questionable whether the resources devoted to premium tax issues are sufficient to adequately perform the required functions.

Of the approximately 1600 licensed and authorized insurance companies in Colorado, approximately 850 collect enough Colorado premiums to be required to file quarterly tax returns. The balance are required only to file an annual return. Tax returns and payments are sent directly to a bank lock box and deposited. The DOI receives a copy of the deposit slip and the tax return from the bank. This process is very similar to the system businesses currently use for the deposit of payroll taxes.

Once the tax return is received by the DOI, it is logged in and verified by the DOI personnel. Funds are forwarded from the bank deposit account to the State Treasurer's Office for deposit to the general fund. Companies that have not filed a return by the quarterly or annual due date are sent a notice to file.

It is the responsibility of the company filing to ensure compliance with all applicable tax requirements for Colorado. This can be complex for some companies. All states have implemented retaliatory tax provisions in their insurance codes. This means an insurance company based in another state pays the premium tax rate that Colorado-based insurance companies would have to pay in that state. Many companies file tax returns in several states,. Individual states have a wide variety of allowable deductions, tax rates, and tax systems. It is common for tax returns to contain errors.

There are exceptions to the retaliatory tax provision. If a company establishes a qualified Regional Home Office, it is subject to a flat 1 percent premium tax. This provision was established as an economic incentive to promote insurance-related employment opportunities in Colorado. Common mistakes on returns are using the Regional Home Office rate or the Colorado domestic company rate in place of the retaliatory rate. As part of the screening process, all returns using the home office rate are reviewed.

Premium tax returns are reviewed for accuracy and screened for unusual deductions or fluctuations from previous returns. Returns identified by the screening process are then further reviewed for a potential audit. The DOI requests additional information or "desk audits" approximately 15 percent of the premium tax returns. All audits are triggered by the screening process; there are no random audits conducted.

The DOI dedicates approximately one (1) FTE to receive, log, screen, and audit returns. Desk audits are performed on approximately 15 percent of the premium tax returns. In order to perform the audit, requests are made by mail to obtain additional information, clarification of deductions, or documentation. Audits are frequently conducted in excess of 12-18 months after the return is filed. Approximately 50 percent of the audited returns are found to contain errors resulting in additional tax assessments, fines, interest, penalties and occasionally, refunds. For the tax year ending 1995, the DOI collected $355,718 in additional taxes, penalties and interest, or about .3 percent of the premium tax collected.

In addition to processing and auditing premium tax returns, the Premium Tax Unit is responsible for processing refund requests and credits vouchers after it is satisfied with the result of the review of the tax return. This unit is also responsible for the collection of surplus line broker's tax, unlicensed companies' tax, and annual fee assessment from nontraditional companies, such as HMOs, prepaid dental plans, nonprofit hospitals, or medical, surgical, and health service corporations.

This unit is also responsible for the administration of the statutory deposit. The Commissioner holds deposits for the protection of all policyholders. Insurance companies licensed in this state are required to deposit securities from a minimum of $300,000 to a maximum of $2,000,000 in a joint deposit with the Commissioner. This unit is also responsible for the following:

- Overseeing that the quality and type of investment qualifies for statutory deposit;

- Approving or disapproving the type of investments that qualify for statutory deposits;

- Responding to inquiries from other insurance departments and auditors;

- Confirming the balance of deposits; and

- Meeting with company officials for depositing and withdrawing securities at various banks in Downtown Denver.

By comparison, the Colorado Department of Revenue (DOR) collected $139,525,000 from business taxes last year. To fulfill this obligation, DOR utilized approximately 7.5 FTE as field auditors. Tax returns are screened and identified returns are subject to review by a tax examiner for a potential audit. In addition to returns identified by the screening process, DOR conducts random audits of business tax returns. Field audit staff of the DOR indicate most audited returns contain errors, and a majority of those result in the collection of additional revenues. In Fiscal Year 1995, the audit of business tax returns resulted in the assessment of an additional $25 million in taxes, fees and penalties, or about 18 percent of the tax collected. All DOR audits are conducted on site.

On March 1 of each year, insurance companies are required to file premium tax returns. Overpayments and underpayments are settled on a yearly basis by the premium tax staff (1 FTE). DOI does not conduct on-site-audits; instead, it relies on the audited companies to supply information. Since the DOI does not have specific authority to audit premium tax returns, some companies have been reluctant to provide documentation to the DOI auditor. DOI has relied on §10-1-203, C.R.S., giving the Commissioner the authority to examine any company and §10-1-204, C.R.S., requiring companies to provide access to all books and records to request information. The Financial Examinations Section does, in conjunction with their financial examination, audit the premium tax returns every five years for domestic companies. By contrast, DOR has specific authority to conduct on-site and paper audits of tax returns at any time.

While insurance companies are not subject to income taxes like other Colorado corporations, they are still subject to audits by DOR for other types of taxes, such as payroll and use taxes. It is conceivable that an insurance company could be subject to simultaneous audits by DOI and DOR, each requesting different types of information and documentation. DOR uses a coordinated audit process; that is, when they perform an on-site audit, they audit several different types of tax returns at one time.

States with similar levels of premiums written were contacted for a comparison of methodology for tax collection. States contacted had a variety of tax collection scenarios. Some states collected premium taxes “in house” similar to the DOI, others had taxes collected by a tax collection agency similar to the Department of Revenue. Some, like Oregon, divide collections between agencies. The average estimate by other states for tax returns containing errors is 8 percent. Of the agencies contacted, Colorado has the lowest FTE to premium tax ratio.

States with more staff devoted to premium tax issues generally audit more returns and collect more in back taxes, penalties, and interest. For example, Arizona, a state with almost identical premium tax revenues, employs two full-time auditors. These auditors perform desk audits similar to those executed by the DOI. However, because it is their sole responsibility, they expect to audit 100 percent of the Arizona premium tax returns in 1996.

It is not reasonable to expect that devoting an additional FTE to premium tax audits will double the assessments for back taxes, penalties, and interest. However, if the error experience of other states holds true in Colorado, it is expected that the increase in revenues collected will greatly exceed the expense of any additional FTE required.

An alternative to devoting additional resources within the DOI to premium tax collections is to shift the collection of premium taxes to the Department of Revenue. On the surface, this alternative seems to have merit. The DOR is in the business of tax collection and has trained, experienced auditors on staff. DOR routinely conducts on-site audits of businesses and may well conduct an audit of an insurance company the same year the DOI does.

However, premium tax assessments are a highly specialized field. Issues regarding retaliatory taxes, premium assessments, and allowable deductions are unique to the insurance industry. Therefore, there would be a steep learning curve for DOR personnel trained in payroll, sales and use, or income tax issues.

Recommendation #19: Establish the Next Sunset Review of the Division of Insurance in 2002

The dynamic nature of the insurance industry and the ever-evolving complexity of insurance issues results in constantly changing regulation. Programs within the Division of Insurance rise and fall depending upon the need for regulation. For these reasons, this report recommends that the next Division of Insurance Sunset Review be conducted in five years. This will allow new programs such as market conduct time to be implemented while also allowing current programs that have been modified as a result of this review to mature before they are subject to another sunset review. At the same time, the proposed five-year date will allow reviewers to address any new changes to the industry.

ADMINISTRATIVE RECOMMENDATIONS

Recommendation #1: Devote more resources to Premium Tax responsibilities

Summary: The collection of taxes is not traditionally viewed as a role of an agency whose mission is consumer protection. However, because of the complexities involved with retaliatory taxes and the fact that insurance companies do not pay income taxes like other types of businesses, it is the responsibility of the DOI.

Through the use of sophisticated computer screening models and training, the DOI has maximized the potential of existing staff. However, existing staff is one person, whose responsibilities are not exclusively devoted to tax return auditing. As a result, no random audits are conducted, Only targeted returns are audited. Frequently, audits are conducted well after the return is filed. There is a large potential for lost revenue due to inaccurate premium tax returns being accepted by the DOI. (See Discussion beginning on page 123.)

Recommendation #2: The Commissioner should reevaluate the fee structure promulgated under the Single Producer Licensing Act

Summary: The Single Producer Licensing Act was established in 1993 to streamline and simplify the licensing procedure for both licensees and the DOI. To implement this program, the Commissioner was required to promulgate a regulation implementing fees for activities associated with the licensing process. The Act was generally supported by insurance companies, agencies, and agents (producers), with the understanding that fees would be revenue-neutral to the producers and agencies.

***Discussion*:** After the first cycle of licensing under the new system some producers and agencies have discovered they are subject to fees substantially higher than under the old system. Services that previously had been free, such as change of address and letters of good standing, now carry fees. Not only are these services subject to registration fees by the DOI, but the DOI must also collect the excise tax of $9 collected on all license and registrations issued by DORA. This places an unreasonable burden on insurance producers and should be corrected.

Many of the functions related to licensing were also privatized under the single producer act. A component of any privatization plan should be that the fees collected are sufficient to cover the costs associated with the privatized activity. While it is reasonable to require programs to fund themselves, the level of increase for this program seems to be excessive. Producers interviewed for this report cited examples of independent agencies being subjected to effective annual fee increases of over 200 percent.

Recommendation #3: The Commissioner should establish an objective evaluation of the benefits of mandatory continuing education for insurance producers.

Summary: The General Assembly implemented a mandatory continuing education requirement for insurance producers in 1992. Since that time, the DOI has approved over 6000 classes for continuing education credit. The procedure to obtain approval is simple. Applicants submit a course summary, course materials, and background information on the instructors. Provided it meets guidelines for relevancy and the instructors meet minimum qualifications, the course is approved. Any producer attending the class receives credit toward the mandatory continuing education requirement to maintain licensure in Colorado.

There is currently no objective evaluation of the effectiveness the continuing education requirement has on consumer protection. Since the program is so new, this would be an ideal time to establish measurement standards so that a determination on its effectiveness can be made during the next sunset process.

***Discussion*:** §24-34-904(1)(B)(n) C.R.S., requires that any bill containing mandatory continuing education requirements for a profession or occupation licensed or regulated be objectively analyzed for necessity and benefits prior to its introduction in the General Assembly. Research for this report did not reveal an objective evaluation for mandatory continuing education (MCE).

Insurance producers are required to obtain 24 hours of approved continuing education over a two-year renewal cycle. The Commissioner may require that up to six hours of MCE in any given renewal cycle be in a specific area of education. Monitoring of compliance is performed by the same private contractor that administers the producer licensing program.

The DOI approves all MCE courses. Courses are screened to ensure course content is relevant and is not intended for personal enrichment or sales training. Courses must be taught by qualified instructors. Only "self-study" or correspondence courses are required to utilize any kind of competency evaluation upon completion of the education program.

Organizations or educational institutions providing MCE classes submit an application to the Commissioner. Application information includes:

- An outline of the course;
- A copy of the table of contents of the textbooks used;
- A sample competency examination (self study-courses only);
- The course filing fee (except for insurers paying fees under §10-3-207 C.R.S.);
- The number of hours proposed for the course;
- The qualifications of the instructor; and
- The date of course initiation.

Once approved, course information must be updated every five years. Course providers are required to maintain records to verify the attendance and successful course completion for all producers enrolled in a course. The DOI does not routinely audit courses to verify information contained in the course application is correct.

In general, the benefits of MCE programs are questionable. Advocates of MCE provide anecdotal information and emotional appeals to justify programs. They argue that it is the role of government to ensure the professional competency of licensed professionals. They maintain MCE is a necessary component to ensure competency.

DORA has been evaluating the continuing education issue periodically for the past several years. The majority of the reports reviewed by DORA have similar findings: continuing education, combined with needs assessments and outcome evaluations, may be of value for licensed professionals. However, there is no evidence that MCE, in itself, promotes continued professional competency.

There is also evidence that MCE programs, because of the expense and time involved, may create a barrier to entry to the professional. Individuals starting out in real estate or insurance on a part-time basis may not have the time or resources to commit to MCE.

Continuing education to improve professional knowledge and skills is an admirable objective for professionals. MCE programs make three assumptions that cannot be supported by empirical evidence: First, that professionals are able to accurately assess their own deficiencies, second, that these individuals will identify courses to address these deficiencies, and third, that by attending courses, the deficiencies will be corrected.

The MCE program for insurance producers, like most MCE programs, does not provide individual needs assessments. In most cases, attending the class is the only criterion for receiving credit. There is no evaluation of retention of presented material and no evaluation of practical application of educational content once the producer has left the lecture.

If MCE is to be justified for insurance producers, an objective evaluation of its effectiveness should be developed. Measurement standards developed by the DOI should be reviewed during the next Sunset Review of the DOI and a recommendation on the continuation of MCE for producers should be included in the sunset report.

Recommendation #4: Due to the seriousness of the problem of domestic abuse and the problems associated with using criteria in underwriting insurance policies, this report recommends that the Division of Insurance develop legislation related to preventing discrimination based on domestic abuse for life, disability, health, and property and casualty insurance

Summary: Domestic abuse is an all too frequent event in society. Its effects create wide-ranging ramifications in many aspects of people's lives including insurance. The use of domestic violence as a criterion to deny insurance or raise rates has received attention in Colorado as well as nationally. A survey of insurers licensed in Colorado reveals that at least 11 percent of insurers use domestic violence in some manner as a criterion in underwriting practices. Currently, eight states prohibit insurers from using domestic abuse in underwriting practices. The use of restrictions of underwriting practices is also supported by industry, which has taken an active role in adopting legislation throughout the country. Additionally, the NAIC is currently reviewing draft model legislation which would prevent discrimination in insurance underwriting based on domestic violence for life, health, disability income, and property and casualty insurance lines. Because of the potential and real problems associated with domestic abuse and its relationship to insurance underwriting, this report recommends that the Division of Insurance propose legislation to address this issue.

Discussion: Over the last couple of years, one issue receiving considerable national attention has been the use of domestic violence as a reason to deny or change an individual's insurance rates. Several large insurers' refusal to underwrite policies for consumers subject to domestic violence created national controversy over this practice. As a result, both federal and state legislators proposed legislation that would eliminate the use of domestic violence as an underwriting criterion. Although no federal legislation has passed, several states have enacted legislation that restricts the use of domestic violence as a criterion when determining rates or issuing policies.[18]

Information presented by State Farm Insurance Company, the Coalition Against Domestic Violence, and the Women's Law Project clearly shows that domestic abuse is a serious component of everyday lives and a serious issue of insurance underwriting. State Farm states the following information when identifying the scope of the problem:

- Between 1.8 and 4 million women are abused in their homes each year.
- Domestic Violence results in approximately 10,000 days of hospitalization, 30,000 emergency department visits, and 40,000 visits to physicians each year.
- Domestic violence permeates all economic levels, races, and religions.
- Most women in violent relationships are socially, legally, materially, and/or emotionally entrapped in their violent relationships. The feelings of being trapped, fear, guilt, low self-esteem, and lack of financial, educational, and occupational resources are among the reasons why victims stay in abusive situations.[19]

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Arizona	A.R.S Title 20, Chapter 16, § 20-2601 (1966).
California	CA INS §10144.2 (1995).
Connecticut	C.G.S.A., Title 38A, Chapter 704, §816(18) (1995).
Florida	FL ST §626.954 (1995).
Iowa	I.C.A. §507B.4 (1996).
Indiana	I.C. §27-8-24.3 (1996).
Massachusetts	M.G.L.A 175 §95B, 176A § 3A, 176B §5A, 176G §19, 175 §108G175 §120D (1995).
Tennessee	T.C.A Title 56, Chapter 8, §§1-8.

[19] "Inside the Issues" State Farm Insurance Companies Mountain States Public Affairs 5/96.

Four areas of insurance discrimination were identified by the Women's Law Project and the Pennsylvania Coalition Against Domestic Violence in their report in March 1996. They are health insurance, life insurance, disability insurance, and property and casualty insurance. Examples include:

1. A Washington state child twice denied health insurance because he had been sexually abused at a day care facility.

2. A Lancaster county, Pennsylvania, woman was unable to obtain reimbursement for emergency room services for injuries resulting from domestic violence under her employer's self-insurance plan. She has been billed over $5,000.

3. An lowa woman was denied a life insurance policy in November, 1993, by Prudential Insurance Company because she had a history of multiple assaults from her boyfriend.

4. Another lowa woman, who was sexually abused as a child and received some counseling, was later denied disability insurance on the basis of earlier treatment.

5. Allstate Insurance Company canceled an Oregon woman's homeowner's insurance in 1994 because her former spouse set fire to her home. Following the cancellation the woman sought other insurance but was repeatedly denied. When she was referred to the Oregon Fair Plan, she was quoted a price eight times what she had been previously paying.

6. A Washington state landlord's policy was canceled because the insurer learned the landlord intended to rent a home to a women's shelter.

7. The Kansas office of the Coalition Against Domestic Violence was denied property insurance because they were "too high-risk," even though they were a two-person administrative office. They were later able to obtain minimal coverage through a Kansas-based company.

In March of 1995, the Pennsylvania Insurance Commissioner surveyed insurance company practices in Pennsylvania. The results showed 26 percent of those who responded used domestic violence as an underwriting criterion. The Kansas Insurance Commission survey of health, life, and accident insurers in October 1995 showed that 24 percent of the insurers used domestic violence as an underwriting criterion.

Because of the proximity of Kansas to Colorado and its survey on domestic abuse, consumer and industry interest in addressing this problem, and the national attention received over this issue, the DORA conducted its own voluntary survey of property, casualty, disability, life, and health insurance companies operating in Colorado. Of the 320 companies surveyed,[20] 175 responded. The results indicate that approximately 11 percent of companies use domestic violence in some manner as a criterion in their underwriting practices. However, this number is somewhat misleading. Many companies who in 1995 stated that they used domestic abuse as an underwriting practice under the Kansas survey did not respond to our survey.[21] It is likely that other companies who follow this practice refused to answer the survey.

It is difficult to say exactly how many people are affected by these practices because insurers are not required to tell applicants the reason for rejections or other adverse actions and victims may not know that domestic abuse was an underwriting criterion. The states that have recently passed legislation prohibiting domestic abuse as an underwriting criterion, have not had hard data to support the need for legislation. They cannot show victims but have made the presumption that if some insurance companies are using domestic abuse as an underwriting criterion, someone is being discriminated against. Despite the lack of hard data, even insurance companies feel the need for some type of legislation as seen by industry initiatives.

Reasons for Using Domestic Abuse as an Underwriting Criterion

There are several arguments insurance companies have made in the past to support the use of domestic abuse as an underwriting criterion. Some insurers equate domestic violence victims with skydivers or motorcycle riders; they are making a voluntary lifestyle choice and compare battering to a career choice such as washing skyscraper windows for which an insurance company should not be responsible. However, domestic abuse is a crime, not a career or lifestyle choice. The victim should not be punished again by insurance underwriting criterion.

[20] Although there are approximately 1700 companies in Colorado, the survey limited participants who made up 95 percent of the market for the following lines of insurance: 1) life, 2) accident and health, 3) HMO and nonprofit (100 percent), 4) homeowners, and 5) private passenger auto.

[21] There are at least five companies identified that did not respond.

Others argue domestic violence is a risk factor that needs to be considered by insurers. Limiting their ability to do so will affect the insurer's ability to offer affordable insurance products. However, many insurance companies do not use domestic violence as an underwriting criterion and they are able to stay in business and offer affordable products. Additionally, there are no actuarial studies offered by insurers that show domestic violence is a particular risk that changes the overall cost of insurance.

A third argument is that insuring the life of the victim gives the batterer an incentive to kill and collect on the policy, and if the insured is killed, the insurance company could be sued for issuing a policy with knowledge of a history of domestic violence. Domestic violence experts have concluded however, that batterers abuse for power, not profit, and insurance companies are already protected from suit by contract and law. Insurance policy provisions typically prohibit beneficiaries from recovering when the death is caused by intentional misconduct.

In 1994, State Farm Insurance denied medical, life, and mortgage disability insurance to a Pennsylvania woman because of her "unstable family environment." The issue attracted national attention and State Farm has since changed its policies. State Farm also formed the not-for-profit Corporate Alliance to End Partner Violence in 1995. In addition to the creation of this organization, State Farm is spearheading legislation related to preventing underwriting discrimination of domestic violence victims throughout the country. Fearing that some existing state legislation was too restrictive, State Farm has created their own model act to prevent discrimination in rating or denying life and health insurance to victims of domestic abuse. (See Appendix.) This winter, State Farm Insurance Company plans to propose a model bill amending the Unfair Trade and Practices Act in Wyoming, Utah, and Colorado to address part of this domestic violence problem. State Farm introduced their model act in Utah in 1996, but their proposal was defeated in committee through the efforts of the Utah Coalition Against Domestic Violence citing that the language was too weak to be effective.

At the same time, the NAIC has met and developed guidelines to deal with discrimination against victims of domestic abuse. It currently has created three model final drafts and one model act which prevent discrimination in property, casualty, life, health, and disability lines of insurance. (See Appendix.)

Currently, State Farm is initiating an effort to enact legislation in Colorado. They are meeting with interested parties to outline model legislation. Because of its impending proposal, DORA reviewed the merits of the State Farm model act in its current form.

The Proposed State Farm Bill

The stated purpose of the bill State Farm wants to introduce in Colorado is to ensure victims of domestic violence are not discriminated against when buying life and health insurance. In principle, it would put consumers who are/have been victims of domestic violence on a level playing field with all others. Under Section I, insurance companies could not consider an applicant's history of abuse in selling or rating life or health insurance. The act of denying or limiting health or life insurance benefits or coverage on the basis of domestic abuse would be considered an unfair trade practice.

Section II of the bill deals with applicability and scope of the bill. It states the bill would apply to all policies issued in the state after the effective date and includes existing contracts which are renewed on or after the effective date when the bill becomes law.

Sections III and IV define "underwriting" and specify what acts constitute unfair and discriminatory practices. For example, an insurer may not charge a domestic abuse victim different rates for health or life insurance coverage based on the fact the applicant has been a victim of domestic abuse. However, there is a limitation proposed in Section VI, which states an insurer may underwrite because of a physical or mental condition as long as the refusal to insure, the limiting of coverage, or the rate differential is based on actual or reasonably anticipated experience.

Section V limits the investigation of applicants by insurance companies. Applicants may not be asked whether the applicant is or has been the subject of domestic violence. This section also includes immunity for the insurer who issues a health or life insurance policy to someone who is or has been a victim of domestic violence. The insurance company cannot be subject to criminal or civil liability for the death or injuries suffered by a person as a result of domestic violence.

Evaluation of the Bill

In general, the scope of the protection offered by this model act only covers life and health, but offers no protection for property and casualty and disability income insurance. Additionally, State Farm's proposed legislation does not contain other necessary provisions and definitions. Below is a detailed evaluation of the proposed industry legislation.

Section I

While the stated purpose of Section I of the bill is to prohibit insurance companies' denying benefits and coverage on the basis of domestic abuse, the bill does not define domestic abuse. To prevent insurance companies from using their own interpretation of domestic abuse, the definition from the Colorado Revised Statutes should be included. It states:

§14-4-101. Definitions
As used in this article, unless the context otherwise requires:

(1) "Adult" means an individual eighteen years of age or over.

(2) "Domestic abuse" means an act or threatened act of violence that is committed by any person against another person with whom the actor is a current or former relation, or with whom the actor is living or has lived in the same domicile, or with whom the actor is involved or has been involved in an intimate relationship.

(3) "Emancipated minor" means an individual under eighteen years of age who is married and living away from his parents or guardian.

Including the Colorado definition of domestic abuse more clearly defines what is meant by domestic abuse and broadens the scope of the State Farm bill to include not only spousal domestic abuse but abuse against children. The statute specifies abuse is "committed by any person against another person."

This section also needs to include language defining an "abuse-related medical condition" and "abuse status." Effective language can be found in the Tennessee statute. It says: (2) "Abuse-related medical condition" means a medical condition sustained by a subject of abuse which arises in whole or part out of an act or pattern of abuse.

(4) “Abuse status” means the fact or perception that a person is, has been, or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions or has incurred abuse-related claims. T.C.A. Title 56, Chapter 8 §§1-8 (1996).

Section II

The type of insurance coverage by State Farm's model act, is limited by Section II to health and life policies only. This should be expanded to include property and casualty and disability unless the industry can sufficiently explain why it should not be included. Only one state, Massachusetts, has enacted legislation to include property and casualty. The statute prohibits cancellation, refusal to renew, or permit any distinction in the amount of premiums or type of coverage based on the insured being a victim of domestic violence.

The statute also specifies that nothing in this section shall be construed as creating a special class of insured who have been victims of domestic violence. M.G.L.A 175 § 95B (1996).

None of the states surveyed have included a provision for disability coverage. This should also be included in Section II. Language is needed prohibiting insurance companies from denying disability insurance because of previous or current domestic abuse.

Section III

The current language in State Farm’s model act only defines the concept of "underwriting." The definitions in Section III need to be expanded to identify the meanings of a health, life, property and casualty, and disability policy. Typically, a health care plan is a policy, contract, or agreement offered by a carrier to provide, deliver, arrange for, pay, or reimburse any costs of health care services. T.C.A. Title 56 §1(4). The concepts of insurer and insured also need defining.

Two of the major problems with the State Farm model act are 1) there are no provisions for accountability to the insured, and 2) the insured has no redress if they believe they have been unfairly denied. Language is needed to compel the insurance companies to justify their actions when denying benefits or coverage. For example, in Arizona's statute, an insurer that takes any adverse action against a victim of domestic violence must notify the victim in writing of the specific reasons why the action occurred. A.R.S. Title 20, Chapter 16, Article 1.

The victim of domestic violence who has been denied coverage or benefits must then have the procedures in place to file a complaint with the Insurance Commissioner. Language needs to be included to give the Insurance Commissioner the authority to investigate and sanction the insurance company. Language found in the Tennessee statute adequately provides for this. It states:

> Underwriting in accordance with the standards set for below shall be deemed not to be a violation of this act. Upon request of the Commissioner a health carrier or insurer of an individual or group policy that has taken an action that adversely affects a subject of abuse on the basis of an abuse-related medical condition must explain the reasons for its action to the Commissioner in writing and must be able to demonstrate that its action:
>
> (1) Does not have the purpose or effect of treating abuse status as a medical condition or underwriting criterion;
>
> (2) Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition or claim is abuse-related; and
>
> (3) Is based on a determination made in conformance with actual or reasonably anticipated actuarial experience.[22]

The NAIC model legislation removes many of the issues associated with the State Farm proposal. The NAIC models expand legislation against domestic abuse to all major insurance lines: health, life, disability, and property and casualty. Additionally, the NAIC models have received input from many more interested parties and reflect the concerns associated with those interests, thereby providing a bill from consensus. At the time of this report, the NAIC model legislation covering discrimination of domestic abuse victims for health insurance is final with the model acts for life, disability, and property and casualty in final draft format.

Because NAIC's models are broader in scope, use more clearly defined language, and result from a broader consensus of interested parties, this report recommends that the Division of Insurance use the NAIC models to create proposed legislation for Colorado.

[22] T.C.A., Title 56 §4.

APPENDICES

Sunset Statutory Evaluation Criteria

(I) Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;

(II) If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;

(III) Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;

(IV) Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;

(V) Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;

(VI) The economic impact of regulation and, if national economic information is available, whether the agency stimulates or restricts competition;

(VII) Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;

(VIII) Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;

(IX) Whether administrative and statutory changes are necessary to improve agency operations to enhance public interest.

State Farm Model Legislation