

## CHAPTER 295

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**INSURANCE**


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**SENATE BILL 04-125**

BY SENATOR(S) Kester, Cairns, Dyer, Entz, Evans, Fitz-Gerald, Gordon, Groff, Grossman, Hanna, Isgar, Johnson S., Jones, Keller, Lamborn, May R., Phillips, Sandoval, Tapia, Taylor, Tupa, Veiga, and Windels;  
also REPRESENTATIVE(S) Mitchell, Carroll, Cloer, Coleman, Frangas, Madden, Merrifield, Miller Paccione, Rose, Weddig, and Williams S.

**AN ACT****CONCERNING THE PROMPT PAYMENT OF AUTO INSURANCE BENEFITS.**

*Be it enacted by the General Assembly of the State of Colorado:*

**SECTION 1.** Part 6 of article 4 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF THE FOLLOWING NEW SECTIONS to read:

**10-4-634. Prompt payment of direct benefits - legislative declaration - definitions.** (1) THE GENERAL ASSEMBLY FINDS, DETERMINES, AND DECLARES THAT PATIENTS AND HEALTH CARE PROVIDERS ARE ENTITLED TO RECEIVE REIMBURSEMENTS FROM AUTO INSURANCE ENTITIES IN A TIMELY MANNER. THEREFORE, IT IS IN THE INTEREST OF THE CITIZENS OF COLORADO THAT REASONABLE STANDARDS BE IMPOSED FOR THE TIMELY PAYMENT OF CLAIMS.

(2) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "CLAIM" MEANS A CLAIM FOR PAYMENT OF MEDICAL PAYMENTS COVERAGE BENEFITS IN ACCORDANCE WITH THE INSURER'S POLICY.

(b) "CLAIMANT" MEANS A POLICYHOLDER, INSURED, OR INJURED PERSON ENTITLED TO MEDICAL PAYMENTS BENEFITS AS A RESULT OF A MOTOR VEHICLE ACCIDENT, OR A PROVIDER WITH THE PROPER ASSIGNMENT OF BENEFITS.

(c) "CLEAN CLAIM" MEANS:

(I) A CLAIM WHERE THERE IS NO ADDITIONAL INFORMATION NEEDED BY THE INSURER TO ACCEPT OR DENY THE CLAIM. A CLAIM REQUIRING ADDITIONAL

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*Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.*

INFORMATION SHALL NOT BE CONSIDERED A CLEAN CLAIM AND SHALL BE PAID, DENIED, OR SETTLED AS SET FORTH IN PARAGRAPH (b) OF SUBSECTION (6) OF THIS SECTION.

(II) A CLAIM FORM THAT IS SUBMITTED WITH, OR AFTER SUBMISSION OF, A PROPERLY EXECUTED APPLICATION FORM FOR BENEFITS CURRENTLY USED BY THE INSURER BY THE POLICYHOLDER, INSURED, OR INJURED PERSON ENTITLED TO BENEFITS.

(3) THE COMMISSIONER MAY, IN CONSULTATION WITH INTERESTED PARTIES, INCLUDING HEALTH CARE PROVIDERS, ADOPT A UNIFORM APPLICATION FORM FOR MEDICAL PAYMENTS BENEFITS OR A UNIFORM CLAIM FORM OR BOTH A UNIFORM APPLICATION AND UNIFORM CLAIM FORM. FOR A UNIFORM CLAIM FORM OR A UNIFORM APPLICATION FORM HAVING ELEMENTS PROVIDED BY A HEALTH CARE PROVIDER, THE COMMISSIONER SHALL CONSIDER THE UNIFORM CLAIM FORMS AND ELEMENTS ADOPTED FOR HEALTH INSURANCE PURSUANT TO SECTION 10-16-106.3. IF THE COMMISSIONER DETERMINES THAT NEW ELEMENTS ARE REQUIRED TO ESTABLISH THAT AN INJURY OR BENEFIT REQUESTED IS THE RESULT OF A MOTOR VEHICLE ACCIDENT, THE NEW ELEMENTS MAY BE LISTED IN A SEPARATE UNIFORM APPLICATION FORM.

(4) (a) A CLAIMANT MAY SUBMIT A CLAIM:

(I) BY UNITED STATES MAIL, FIRST CLASS, OR BY OVERNIGHT DELIVERY SERVICE;

(II) ELECTRONICALLY, IF THE INSURER ACCEPTS CLAIMS ELECTRONICALLY, TO THE LOCATION DESIGNATED BY THE INSURER;

(III) BY FACSIMILE TO THE LOCATION DESIGNATED BY THE INSURER; OR

(IV) BY HAND DELIVERY TO THE LOCATION DESIGNATED BY THE INSURER.

(b) (I) THE PROVIDER MAY CONTACT THE INSURER FOR THE PURPOSE OF RESUBMISSION OF A CLAIM. THE INSURER SHALL HAVE A SEPARATE FACSIMILE PROCESS TO RECEIVE RESUBMITTED PAPER CLAIMS. A RESUBMITTED CLAIM SHALL BE DEEMED RECEIVED ON THE DATE OF THE FACSIMILE TRANSMISSION ACKNOWLEDGMENT.

(II) IF A CLAIM IS SUBMITTED ELECTRONICALLY, IT IS PRESUMED TO HAVE BEEN RECEIVED BY THE INSURER OR THE INSURER'S CLEARINGHOUSE, IF APPLICABLE, ON THE DATE OF THE ELECTRONIC VERIFICATION OF RECEIPT. IF A CLAIM IS SUBMITTED BY FACSIMILE, IT IS PRESUMED TO HAVE BEEN RECEIVED BY THE INSURER OR THE INSURER'S CLEARINGHOUSE, IF APPLICABLE, ON THE DATE OF THE FACSIMILE TRANSMISSION ACKNOWLEDGMENT. IF A CLAIM IS SUBMITTED BY MAIL, IT IS PRESUMED TO HAVE BEEN RECEIVED BY THE INSURER OR THE INSURER'S CLEARINGHOUSE, IF APPLICABLE, THREE BUSINESS DAYS AFTER THE DATE OF MAILING. IF A CLAIM IS SUBMITTED BY OVERNIGHT DELIVERY SERVICE OR BY HAND DELIVERY, IT IS PRESUMED TO HAVE BEEN RECEIVED ON THE DATE OF DELIVERY.

(c) THE PRESUMPTIONS IN PARAGRAPH (b) OF THIS SUBSECTION (4) MAY BE REBUTTED BY:

(I) A DATE STAMP ON A CLAIM SHOWING THE DATE OF RECEIPT. SUCH DATE SHALL BE PRESUMED THE DATE OF RECEIPT.

(II) THE FACT THAT THE INSURER'S RECORDS MAINTAINED IN THE ORDINARY COURSE OF BUSINESS DO NOT EVIDENCE RECEIPT OF A CLAIM. IN SUCH CASE, THE CLAIM SHALL BE DEEMED NOT TO HAVE BEEN RECEIVED BY THE INSURER.

(d) AN INSURER SHALL MAINTAIN CLAIM DATA THAT IS ACCESSIBLE AND RETRIEVABLE FOR EXAMINATION BY THE COMMISSIONER FOR THE CURRENT YEAR AND FOR THE TWO IMMEDIATELY PRECEDING YEARS. FOR EACH CLAIM, AN INSURER SHALL PROVIDE A CLAIM NUMBER, DATE OF LOSS, DATE OF AUTO ACCIDENT, DATE OF RECEIPT OF AN APPLICATION FOR BENEFITS, DATE OF RECEIPT OF A CLAIM, DATE OF PAYMENT OF A CLAIM, AND DATE OF DENIAL OR DATE THE CLAIM IS CLOSED WITHOUT PAYMENT. AN INSURER SHALL DETAIL ALL MATERIAL ACTIVITIES RELATIVE TO A CLAIM. A CLAIM FILE SHALL HAVE ALL MATERIAL DOCUMENTATION RELATIVE TO A CLAIM. EACH MATERIAL DOCUMENT WITHIN A CLAIM FILE SHALL BE NOTED AS TO DATE RECEIVED, DATE PROCESSED, OR DATE SENT. DETAILED DOCUMENTATION SHALL BE CONTAINED IN EACH CLAIM FILE TO PERMIT RECONSTRUCTION OF THE INSURER'S ACTIVITIES RELATIVE TO EACH CLAIM.

(5) (a) EVERY INSURER SHALL PROVIDE A COPY OF ITS CLAIM FILING REQUIREMENTS TO EVERY INSURED OR PROVIDER UPON REQUEST WITHIN FIFTEEN CALENDAR DAYS AFTER THE REQUEST IS RECEIVED BY THE INSURER.

(b) EVERY INSURER SHALL, WITHIN FIFTEEN CALENDAR DAYS AFTER RECEIPT OF A NOTIFICATION OF LOSS, AN APPLICATION FOR BENEFITS, OR A CLAIM, PROVIDE THE NECESSARY APPLICATION OR CLAIM FORMS AND INSTRUCTIONS SO THAT THE CLAIMANT CAN COMPLY WITH THE POLICY CONDITIONS.

(6) (a) CLEAN CLAIMS SHALL BE PAID, DENIED, OR SETTLED WITHIN THIRTY CALENDAR DAYS AFTER RECEIPT BY THE INSURER IF SUBMITTED ELECTRONICALLY AND WITHIN FORTY-FIVE CALENDAR DAYS AFTER RECEIPT BY THE INSURER IF SUBMITTED BY ANY OTHER MEANS.

(b) IF THE RESOLUTION OF A CLAIM REQUIRES ADDITIONAL INFORMATION, THE INSURER SHALL, WITHIN THIRTY CALENDAR DAYS AFTER RECEIPT OF THE CLAIM, GIVE TO THE CLAIMANT A FULL EXPLANATION IN WRITING OF WHAT ADDITIONAL INFORMATION IS NEEDED TO RESOLVE THE CLAIM, INCLUDING ANY ADDITIONAL MEDICAL OR OTHER INFORMATION RELATED TO THE CLAIM. THE PERSON RECEIVING A REQUEST FOR SUCH ADDITIONAL INFORMATION SHALL SUBMIT ALL ADDITIONAL INFORMATION REQUESTED BY THE INSURER WITHIN THIRTY CALENDAR DAYS AFTER RECEIPT OF SUCH REQUEST. THE INSURER MAY DENY A CLAIM IF A PROVIDER RECEIVES A REQUEST FOR ADDITIONAL INFORMATION AND FAILS TO TIMELY SUBMIT ADDITIONAL INFORMATION REQUESTED UNDER THIS PARAGRAPH (b), SUBJECT TO THE RESUBMITTAL OF THE CLAIM OR TERMS OF THE POLICY. IF SUCH PERSON HAS PROVIDED ALL SUCH ADDITIONAL INFORMATION NECESSARY TO RESOLVE THE CLAIM, THE CLAIM SHALL BE PAID, DENIED, OR SETTLED BY THE INSURER WITHIN THIRTY DAYS AFTER RECEIPT OF ADDITIONAL INFORMATION OR AFTER THE APPLICABLE TIME PERIOD SET FORTH IN PARAGRAPH (c) OF THIS SUBSECTION (6).

(c) ABSENT FRAUD, ALL CLAIMS OTHER THAN CLEAN CLAIMS SHALL BE PAID,

DENIED, OR SETTLED WITHIN NINETY CALENDAR DAYS AFTER RECEIPT BY THE INSURER; EXCEPT THAT THE COMMISSIONER MAY ADOPT RULES FOR THE PURPOSE OF EXEMPTING AN INSURER FROM THE REQUIREMENT THAT THE INSURER PAY, DENY, OR SETTLE A CLAIM WITHIN NINETY CALENDAR DAYS IN CIRCUMSTANCES WHERE THE INVESTIGATION OF A CLAIM BY THE INSURER IS INCOMPLETE OR OTHERWISE NEEDS TO BE CONTINUED AND FOR EXTRAORDINARY OR UNUSUAL CLAIMS WITH EXTENUATING CIRCUMSTANCES AS DETERMINED BY THE COMMISSIONER. THE RULES SHALL REQUIRE THE INSURER, WITHIN THIRTY DAYS AFTER THE RECEIPT OF A CLAIM AND EVERY THIRTY DAYS THEREAFTER, TO SEND TO THE CLAIMANT OR THE CLAIMANT'S REPRESENTATIVE, AND TO THE HEALTH CARE PROVIDER IF APPLICABLE, A LETTER SETTING FORTH THE REASONS WHY ADDITIONAL TIME IS NEEDED. THE INSURER THAT IS EXEMPT FROM THE NINETY-DAY TIME PERIOD DUE TO CIRCUMSTANCES WHERE AN INVESTIGATION IS INCOMPLETE OR OTHERWISE NEEDS TO BE CONTINUED SHALL PAY, DENY, OR SETTLE THE CLAIM WITHIN ONE HUNDRED EIGHTY DAYS AFTER RECEIPT OF THE CLAIM. AN INSURER THAT IS EXEMPT FROM THE NINETY-DAY TIME PERIOD SHALL NOT BE EXEMPT FROM PAYMENT OF THE INTEREST DUE PURSUANT TO SUBSECTION (7) OF THIS SECTION.

(d) NO INSURER SHALL DENY A CLAIM ON THE GROUNDS OF A SPECIFIC POLICY PROVISION, CONDITION, OR EXCLUSION UNLESS REFERENCE TO SUCH PROVISION, CONDITION, OR EXCLUSION IS INCLUDED IN THE DENIAL. THE DENIAL SHALL BE IN WRITING AND GIVEN TO THE CLAIMANT, AND THE CLAIM FILE SHALL CONTAIN DOCUMENTATION OF THE BASIS FOR THE DENIAL. THE COMMISSIONER MAY ADOPT A RULE REGARDING THE TIME PERIOD FOR DELIVERY OF THE DENIAL TO THE CLAIMANT, WHICH SHALL BE THE SAME OR SHORTER TIME PERIOD THAN THE PERIOD IN WHICH THE CLAIM WAS DELIVERED.

(7) AN INSURER THAT FAILS TO PAY, DENY, OR SETTLE A CLEAN CLAIM IN ACCORDANCE WITH PARAGRAPH (a) OF SUBSECTION (6) OF THIS SECTION OR FAILS TO TAKE OTHER REQUIRED ACTION WITHIN THE TIME PERIODS SET FORTH IN PARAGRAPH (b) OF SUBSECTION (6) OF THIS SECTION SHALL BE LIABLE FOR THE COVERED BENEFIT AND, IN ADDITION, SHALL PAY TO THE CLAIMANT INTEREST AT THE RATE OF TEN PERCENT PER ANNUM FOR THE FIRST ONE HUNDRED EIGHTY DAYS AND AT THE RATE OF FIFTEEN PERCENT PER ANNUM THEREAFTER, ON THE TOTAL AMOUNT ULTIMATELY ALLOWED ON THE CLAIM, ACCRUING FROM THE DATE PAYMENT WAS DUE PURSUANT TO SUBSECTION (6) OF THIS SECTION. EXCEPT FOR SHORTER TIME PERIODS FOR CLEAN CLAIMS, ALL INTEREST BEGINS TO ACCRUE NINETY CALENDAR DAYS AFTER RECEIPT OF THE CLAIM BY THE INSURER.

(8) IF AN INSURER DELEGATES ITS CLAIMS PROCESSING FUNCTIONS TO A THIRD PARTY, THE DELEGATION AGREEMENT SHALL PROVIDE THAT THE CLAIMS PROCESSING ENTITY SHALL COMPLY WITH THE REQUIREMENTS OF THIS SECTION. ANY DELEGATION BY THE INSURER SHALL NOT BE CONSTRUED TO LIMIT THE INSURER'S RESPONSIBILITY TO COMPLY WITH THIS SECTION OR ANY OTHER APPLICABLE PROVISION OF THIS ARTICLE.

(9) THIS SECTION SHALL NOT APPLY TO CLAIMS FILED PURSUANT TO THE "WORKERS' COMPENSATION ACT OF COLORADO", ARTICLES 40 TO 47 OF TITLE 8, C.R.S.

(10) THE COMMISSIONER MAY INVESTIGATE CLAIMS AGAINST AN INSURER THAT IS

AUTHORIZED TO CONDUCT BUSINESS IN THIS STATE WHEN SUCH CLAIMS ARE FILED BY A PROVIDER RELATED TO THE IMPROPER HANDLING OR DENIAL OF BENEFITS PURSUANT TO THIS SECTION.

(11) THE COMMISSIONER MAY IMPOSE, AFTER PROPER NOTICE AND HEARING, ANY OTHER PENALTIES SET FORTH IN THIS TITLE AGAINST AN INSURER WHO HAS A PATTERN AND PRACTICE OF VIOLATIONS OF THIS SECTION.

(12) WHEN AN INSURED ENTITLED TO BENEFITS UNDER MEDICAL PAYMENTS COVERAGE IS INJURED OR BELIEVES THAT HE OR SHE HAS BEEN INJURED IN AN ACCIDENT AND IS EXAMINED OR TREATED BY A HEALTH CARE PROVIDER, SUCH HEALTH CARE PROVIDER SHALL NOTIFY THE INSURER WITHIN THIRTY CALENDAR DAYS AFTER THE INSURED'S INITIAL VISIT. THIS SUBSECTION (12) SHALL NOT APPLY TO A HOSPITAL OR OTHER HEALTH FACILITY OR ENTITY LICENSED OR CERTIFIED PURSUANT TO SECTION 25-1.5-103 (1), C.R.S.

**10-4-635. Electronic claim forms.** THE COMMISSIONER MAY PROMULGATE RULES, CONSISTENT WITH SECTION 10-4-634, FOR AN INSURER TO ACCEPT CLAIM FORMS FOR MEDICAL PAYMENTS COVERAGE BENEFITS FROM HEALTH CARE PROVIDERS IN ELECTRONIC FORM. AN INSURER SHALL NOT PROHIBIT THE SUBMISSION OF A MEDICAL PAYMENTS COVERAGE BENEFIT CLAIM IN HARD-COPY FORM, NOR SHALL AN INSURER BE PROHIBITED FROM REQUIRING THAT A CLAIM BE SUBMITTED IN HARD-COPY FORM. AN INSURER SHALL NOT REQUIRE SUBMISSION OF A MEDICAL PAYMENTS COVERAGE BENEFIT CLAIM FORM OTHER THAN THOSE SET FORTH IN SECTION 10-4-634.

**SECTION 2.** 10-3-1104 (1) (h), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBPARAGRAPH to read:

**10-3-1104. Unfair methods of competition and unfair or deceptive acts or practices.** (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

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

(XVII) FAILING TO ADOPT AND IMPLEMENT REASONABLE STANDARDS FOR THE PROMPT RESOLUTION OF MEDICAL PAYMENT CLAIMS.

**SECTION 3.** 10-3-1110 (2), Colorado Revised Statutes, as amended by section 2 of House Bill 04-1234, enacted at the second regular session of the Sixty-fourth General Assembly, is amended to read:

**10-3-1110. Regulations.** (2) The commissioner may, after notice and hearing, as provided in article 4 of title 24, C.R.S., promulgate rules with respect to the payment of benefits under group and individual contracts of property or casualty coverage, issued by organizations authorized to do business in this state under the provisions of article 4 of this title; except that, to the extent that a provision of this subsection (2) conflicts with section 10-4-634, AS ENACTED BY SENATE BILL 04-125, ENACTED AT THE SECOND REGULAR SESSION OF THE SIXTY-FOURTH GENERAL

ASSEMBLY, the provisions of SAID section 10-4-634, shall govern. Such rules may establish a penalty payable to the claimant on benefit payments that are delayed more than sixty days after a valid and complete filing of the claim unless there is a reasonable dispute between the parties concerning such claim. Such penalty shall not exceed twenty dollars on claims of less than one hundred dollars or interest at a rate of eight percent annually on claims above one hundred dollars. In addition to such penalties payable to the claimant, the commissioner, after notice and hearing, may assess a civil penalty against any insurer of one hundred dollars per day for each day benefit payments are delayed more than sixty days after a valid and complete filing of the claim unless there is a reasonable dispute between the parties concerning such claim.

**SECTION 4. Effective date - applicability.** This act shall take effect July 1, 2004, and shall apply to claims filed on or after said date; except that section 3 of this act shall only take effect if House Bill 04-1234 is enacted and becomes law.

**SECTION 5. Safety clause.** The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: May 27, 2004