**First Regular Session**
**Sixty-fourth General Assembly**
**STATE OF COLORADO**

**PREAMENDED**

*This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading*

LLS NO. 03-0579.02 Julie Hoerner **HOUSE BILL 03-1225**

## HOUSE SPONSORSHIP

**Williams T.,** Spradley, King, Cadman, and Williams S.

## SENATE SPONSORSHIP

**McElhany,** Andrews, Anderson, and Owen

**House Committees**
Business Affairs & Labor

**Senate Committees**

## A BILL FOR AN ACT

**CONCERNING COLORADO MOTOR VEHICLE INSURANCE.**

### Bill Summary

*(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)*

Repeals and reenacts personal injury protection (PIP) coverage for motor vehicle insurance. Provides:

- $25,000 for legal liability coverage for bodily injury or death arising out the use of a motor vehicle;
- $50,000 for medical benefit coverage for any one motor vehicle accident for reasonable expenses for medically necessary care and treatment; and
- $50,000 for rehabilitation benefit coverage for any one motor vehicle accident for reasonable expenses for

medically necessary care and treatment;

- Deductibles and coinsurance;
- Reduced PIP coverage for persons within 185% of the federal poverty level;
- An option for wage loss benefits; and
- An option for essential services;

Limits the time in which benefits may be claimed. Creates 3 optional policy types, specifically:

- Basic:
  - Requires that care and treatment be received through a primary participating physician and such care must be medically necessary;
- Managed care:
  - Requires that care and treatment be received through a primary participating physician through a managed care arrangement and such care must be medically necessary; and
- Direct access:
  - Allows medically necessary care and treatment to be received from any health care provider.

Allows for extended PIP coverage for persons under the age of 13 who are injured in a motor vehicle accident.

Requires the insurance commissioner to contract with a program manager for the development of treatment protocols, a participation program of practitioners, and external review process for the denial of benefits. Creates a process for an internal review for the denial of benefits. Changes when a person may sue for noneconomic damages. Exempts motor vehicle insurers from the provisions of the consumer protection code. Requires the functions of the commissioner and the program manager to undergo a sunset review in 2006. Repeals this compulsory motor vehicle insurance July 1, 2007.

Makes legislative findings. Defines terms. Makes conforming amendments.

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

**SECTION 1.** 10-4-702, Colorado Revised Statutes, is amended to read:

**10-4-702. Legislative declaration.** (1) The general assembly declares that its purpose in enacting this part 7 is to ~~avoid inadequate compensation to victims of automobile accidents; to require registrants~~

~~of motor vehicles in this state to procure insurance covering legal liability arising out of ownership or use of such vehicles and also providing benefits to persons occupying such vehicles and to persons injured in accidents involving such vehicles~~ REQUIRE REASONABLE AND AFFORDABLE MOTOR VEHICLE INSURANCE IN THIS STATE, WHILE BALANCING PREMIUM COSTS AGAINST THE BENEFITS PROVIDED.

(2) THE GENERAL ASSEMBLY FURTHER DECLARES THAT, AS A RESULT OF INCREASING COST AND RESULTING LACK OF AFFORDABILITY, SIGNIFICANT REFORMS OF COLORADO MOTOR VEHICLE INSURANCE ARE NECESSARY. IT IS THE INTENT OF THE GENERAL ASSEMBLY TO RETAIN COMPULSORY MOTOR VEHICLE INSURANCE WHERE BENEFITS ARE OBTAINED WITHOUT REGARD TO THE FAULT OF THE DRIVER (NO FAULT) IN COLORADO, WHILE MAKING IT MORE AFFORDABLE. THE GENERAL ASSEMBLY FINDS THAT NO FAULT INSURANCE SHOULD BE MORE AFFORDABLE IF AVAILABLE SERVICES ARE BASED ON A STANDARD OF MEDICAL NECESSITY FOR CARE AND TREATMENT AND THE USE OF APPROVED MEDICAL TREATMENT GUIDELINES. THE RESULT OF MEDICAL NECESSITY AND THE USE OF MEDICAL TREATMENT GUIDELINES IS A REDUCTION IN INAPPROPRIATE AND EXCESSIVE UTILIZATION WHILE AFFORDING AUTO ACCIDENT VICTIMS ACCESS TO SERVICES NEEDED TO ACHIEVE APPROPRIATE MEDICAL IMPROVEMENT. TO SUCH ENDS, THESE REFORMS ALSO INCLUDE GIVING CONSUMERS A CHOICE OF SEVERAL NO FAULT POLICY CHOICES AND OPTIONAL BENEFIT COVERAGE PACKAGES. UNNECESSARY LITIGATION WILL ALSO BE REDUCED BY THE ENACTMENT OF THESE REFORMS, WHICH STRENGTHENS THE ORIGINAL INTENT OF NO FAULT INSURANCE LAW.

**SECTION 2.** 10-4-703 (1), (2.5), and (6), Colorado Revised

Statutes, are amended, and the said 10-4-703 is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

**10-4-703. Definitions.** As used in this part 7, unless the context otherwise requires:

(1) ~~"Commissioner" means the commissioner of insurance~~ "ACCIDENT" MEANS, IN CONNECTION WITH THE USE OF A MOTOR VEHICLE, AN EVENT THAT RESULTS FROM THE OPERATION OR USE OF A MOTOR VEHICLE AS TRANSPORTATION, THAT CAUSES BODILY INJURY OR PROPERTY DAMAGE, AND THAT IS UNFORESEEN, UNPLANNED, OR UNINTENDED FROM THE POINT OF VIEW OF THE PERSON WHO SUSTAINS SUCH INJURY OR PROPERTY DAMAGE.

(1.3) (a) "BODILY INJURY" MEANS BODILY AND PHYSICAL INJURY TO AN ELIGIBLE INJURED PERSON AND SICKNESS, DISEASE, OR DEATH THAT RESULTS FROM THE BODILY INJURY.

(b) "BODILY INJURY" SHALL INCLUDE MENTAL OR EMOTIONAL CONDITIONS ONLY IF SUCH CONDITIONS RESULT FROM EITHER:

(I) IMMEDIATELY LIFE- OR LIMB-THREATENING INJURIES TO THE INSURED OR OTHERS IN THE MOTOR VEHICLE ACCIDENT, OR DEATH OF ANOTHER PERSON IN OR AS A RESULT OF THE MOTOR VEHICLE ACCIDENT; OR

(II) MENTAL OR EMOTIONAL CONDITIONS AS A DIRECT RESULT OF SERIOUS AND OBJECTIVELY MANIFESTED DISABLING PHYSICAL INJURY TO THE INSURED BECAUSE OF THE MOTOR VEHICLE ACCIDENT.

(1.5) "COMMISSIONER" MEANS THE COMMISSIONER OF INSURANCE.

(2.5) "Converter" means a person other than a named insured, RESIDENT SPOUSE, or resident relative who operates or uses a motor vehicle ~~in a manner that a reasonable person would determine was~~

~~unauthorized or beyond the scope of permission given by a named insured or resident relative. In determining whether a person is a converter, the following factors should be considered:~~ WITHOUT THE EXPRESS PERMISSION OF THE NAMED INSURED OR RESIDENT SPOUSE OR, IF EXPRESS PERMISSION WAS GRANTED AND IF SUCH PERMISSION INCLUDED LIMITATIONS OF USE OR PERMISSION FOR ONLY ONE OR MORE SPECIFIC PURPOSES, BEYOND THE SCOPE OF SUCH EXPRESS PERMISSION.

~~(a) The duration of the person's control over the vehicle;~~

~~(b) The circumstances surrounding the conduct of the person operating or using the motor vehicle;~~

~~(c) The person's good faith.~~

(5.5) "ELIGIBLE INJURED PERSON" MEANS A PERSON WITHIN ANY OF THE CATEGORIES OF PERSONS DESCRIBED IN SECTION 10-4-701 (1) AND ANY ELIGIBLE PEDESTRIAN.

(6) "Insured" means the named insured, relatives of the named insured who reside in the same household as the named insured, or any person using the described motor vehicle with the permission of the named insured. "INSURED" ALSO MEANS AN ENROLLEE IN A MANAGED CARE POLICY ISSUED PURSUANT TO SECTION 10-4-706.4.

(6.5) "INSURER" SHALL HAVE THE SAME MEANING AS IN SECTION 10-1-102 (8), INCLUDING, BUT NOT LIMITED TO, A MANAGED CARE PLAN AS DEFINED IN SECTION 10-16-102 (26.5).

(6.7) "MAXIMUM MEDICAL IMPROVEMENT" MEANS A POINT IN TIME WHEN ANY MEDICALLY DETERMINABLE PHYSICAL OR MENTAL IMPAIRMENT AS A RESULT OF INJURY HAS BECOME STABLE AND WHEN NO FURTHER TREATMENT IS REASONABLY EXPECTED TO IMPROVE THE CONDITION. THE REQUIREMENT FOR FUTURE MEDICAL MAINTENANCE THAT WILL NOT

SIGNIFICANTLY IMPROVE THE CONDITION OR THE POSSIBILITY OF IMPROVEMENT OR DETERIORATION RESULTING FROM THE PASSAGE OF TIME SHALL NOT AFFECT A FINDING OF MAXIMUM MEDICAL IMPROVEMENT. THE POSSIBILITY OF IMPROVEMENT OR DETERIORATION RESULTING FROM THE PASSAGE OF TIME ALONE SHALL NOT AFFECT A FINDING OF MAXIMUM MEDICAL IMPROVEMENT.

(7.5) "MOTOR VEHICLE ACCIDENT" SHALL HAVE THE SAME MEANING AS "ACCIDENT" IN SUBSECTION (1) OF THIS SECTION.

(11.5) "PHYSICIAN" MEANS:

(a) A PERSON LICENSED PURSUANT TO ARTICLE 36 OF TITLE 12 WITH A DOCTORATE IN MEDICINE OR DOCTORATE OF OSTEOPATHY; OR

(b) A PERSON LICENSED PURSUANT TO ARTICLE 35 OF TITLE 12, C.R.S., WITH A DOCTORATE OF DENTISTRY OR A DOCTORATE OF DENTAL MEDICINE.

(11.7) "PROGRAM MANAGER" MEANS THE PERSON OR ENTITY CONTRACTED WITH PURSUANT TO SECTION 10-4-706.9.

(13) "TREATMENT GUIDELINES" MEANS THE GUIDELINES ADOPTED BY THE COMMISSIONER PURSUANT TO SECTION 10-4-706.9 (2) (c).

**SECTION 3.** 10-4-705 (2), Colorado Revised Statutes, is amended to read:

**10-4-705. Coverage compulsory.** (2) ON AND AFTER JANUARY 1, 2004, any owner of a motor vehicle who operates the motor vehicle on the public highways of this state or who knowingly permits the operation of the motor vehicle on the public highways of this state who fails to have in full force and effect a complying policy covering said motor vehicle at the time of any accident, on account of which benefits under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706~~

~~(2) or (3)~~ OR 10-4-706.1 would be payable, shall be personally liable for the payment of such benefits to the person for whom such payment would have been required, if such coverage had been in effect under the terms of section 10-4-707. Such an owner shall have all of the rights and obligations of any insurer under this part 7.

**SECTION 4.** 10-4-706, Colorado Revised Statutes, is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

**10-4-706. Required coverages - complying policies.** (1) ON AND AFTER JANUARY 1, 2004, SUBJECT TO THE LIMITATIONS AND EXCLUSIONS AUTHORIZED BY THIS PART 7, THE COVERAGES REQUIRED FOR COMPLIANCE WITH THIS PART 7 ARE AS FOLLOWS:

(a) **Legal liability.** LEGAL LIABILITY COVERAGE FOR BODILY INJURY OR DEATH ARISING OUT OF THE USE OF THE MOTOR VEHICLE AS TRANSPORTATION TO A LIMIT, EXCLUSIVE OF INTEREST AND COSTS, OF TWENTY-FIVE THOUSAND DOLLARS TO ANY ONE PERSON IN ANY ONE ACCIDENT AND FIFTY THOUSAND DOLLARS TO ALL PERSONS IN ANY ONE ACCIDENT AND FOR PROPERTY DAMAGE ARISING OUT OF THE USE OF THE MOTOR VEHICLE AS TRANSPORTATION TO A LIMIT, EXCLUSIVE OF INTEREST AND COSTS, OF FIFTEEN THOUSAND DOLLARS IN ANY ONE ACCIDENT;

(b) **Medical care and treatment.** COMPENSATION WITHOUT REGARD TO FAULT, UP TO A LIMIT OF FIFTY THOUSAND DOLLARS PER PERSON FOR ANY ONE MOTOR VEHICLE ACCIDENT, FOR PAYMENT OF ALL REASONABLE CHARGES FOR MEDICALLY NECESSARY CARE AND TREATMENT PERFORMED WITHIN THREE YEARS AFTER THE ACCIDENT FOR BODILY INJURY ARISING OUT OF THE MOTOR VEHICLE ACCIDENT;

(c) **Rehabilitation.** (I) COMPENSATION WITHOUT REGARD TO FAULT, UP TO A LIMIT OF FIFTY THOUSAND DOLLARS PER PERSON FOR ANY

ONE MOTOR VEHICLE ACCIDENT FOR PAYMENT OF THE COST OF ALL REASONABLE CHARGES FOR MEDICALLY NECESSARY REHABILITATION PROCEDURES OR TREATMENT AND REHABILITATIVE OCCUPATIONAL THERAPY NECESSARY WITHIN FIVE YEARS AFTER SUCH ACCIDENT.

(II) REHABILITATIVE PROCEDURES, TREATMENT, OR COURSE OF REHABILITATION SHALL MEET THE FOLLOWING STANDARDS:

(A) ANY PROCEDURE OR TREATMENT SHALL BE REASONABLY DESIGNED TO CONTRIBUTE SUBSTANTIALLY TO REHABILITATION, AND THE COST OF ANY PROCEDURE OR TREATMENT SHALL BE REASONABLE IN RELATION TO ITS PROBABLE REHABILITATIVE EFFECTS.

(B) REHABILITATION TREATMENT AND PROCEDURES SHALL BE REASONABLY DESIGNED TO LEAD A PERSON TO THE ATTAINMENT OF AN INJURED PERSON'S MAXIMUM MEDICAL IMPROVEMENT UNDER THE CIRCUMSTANCES RESULTING FROM THE INJURIES SUSTAINED IN THE MOTOR VEHICLE ACCIDENT. THE PURPOSE OF REHABILITATION SHALL BE THE PHYSICAL RESTORATION OF AN INJURED PERSON TO ACTIVITIES OF DAILY LIVING THROUGH THERAPY, COMPARED TO MEDICAL TREATMENT THAT IS TREATMENT FOR THE PHYSICAL INJURY ITSELF.

(d) THE AMOUNT OF COVERAGE IN PARAGRAPH (c) OF THIS SUBSECTION (1) SHALL BE AVAILABLE, UPON THE DIRECTION OF THE INSURED, FOR TREATMENT PERFORMED WITHIN THREE YEARS AFTER THE MOTOR VEHICLE ACCIDENT PURSUANT TO PARAGRAPH (b) OF THIS SUBSECTION (1). THE COVERAGE IN PARAGRAPH (b) OF THIS SUBSECTION (1) SHALL NOT BE AVAILABLE FOR TREATMENT PURSUANT TO PARAGRAPH (c) OF THIS SUBSECTION (1).

(e) **Death benefits.** COMPENSATION ON ACCOUNT OF DEATH OF A PERSON FOR WHOM DIRECT BENEFITS ARE PROVIDED UNDER THIS SECTION,

PAYABLE TO THE ESTATE OF THE DECEASED, IN THE TOTAL AMOUNT OF ONE THOUSAND DOLLARS.

(2) **Maximum medical improvement.** WHEN A PERSON ENTITLED TO BENEFITS PURSUANT TO THIS SECTION REACHES MAXIMUM MEDICAL IMPROVEMENT AS DETERMINED BY THE PERSON'S PRIMARY PARTICIPATING PHYSICIAN OR A PHYSICIAN DESIGNATED BY THE PRIMARY PARTICIPATING PHYSICIAN, THE COVERAGE AVAILABLE PURSUANT TO SUBSECTION (1) OF THIS SECTION SHALL ONLY COVER BENEFITS TO PROVIDE SUCH TREATMENT AS IS MEDICALLY NECESSARY TO PREVENT THE DECLINE OF THE PERSON'S CONDITION, SUBJECT TO THE LIMITS PRESCRIBED IN THIS SECTION. THE TREATMENT NECESSARY TO OBTAIN MAXIMUM MEDICAL IMPROVEMENT SHALL BE SET FORTH IN WRITING BY THE PRIMARY PARTICIPATING PHYSICIAN AND SHALL BE SUBJECT TO INTERNAL AND EXTERNAL REVIEW PROCEDURES PURSUANT TO SECTIONS 10-4-725.1 AND 10-4-725.2.

(3) **Deductibles and coinsurance.** (a) WITH RESPECT TO THE COVERAGES SET FORTH IN THIS SECTION, AN INSURER SHALL MAKE AVAILABLE AND SHALL PROVIDE, AT THE OPTION OF THE NAMED INSURED, DEDUCTIBLES AND COINSURANCE ARRANGEMENTS IN SUCH AMOUNTS OR PERCENTAGES AS EACH INSURER SHALL DEEM APPROPRIATE.

(b) ANY DEDUCTIBLES AND COINSURANCE ARRANGEMENTS PROVIDED PURSUANT TO THIS SUBSECTION (3) SHALL ONLY APPLY TO THE NAMED INSURED, RESIDENT SPOUSE, RESIDENT RELATIVE, AND PERSONS OPERATING THE COVERED MOTOR VEHICLE WITH THE PERMISSION OF THE NAMED INSURED OR RESIDENT SPOUSE.

(4) **Election of coverage.** AFTER A NAMED INSURED SELECTS A POLICY WITH THE DESIRED PERSONAL INJURY PROTECTION COVERAGE, INCLUDING OPTIONAL COVERAGE PURSUANT TO SECTIONS 10-4-706.2 TO

10-4-706.4, SECTION 10-4-706.6, OR SECTION 10-4-706.1, AN INSURER SHALL NOTIFY SUCH NAMED INSURED IN ANY RENEWAL OR REPLACEMENT POLICY OF THE PERSONAL INJURY PROTECTION COVERAGE SELECTED PURSUANT TO THIS SECTION. AFTER RECEIPT OF SUCH NOTICE, THE NAMED INSURED MAY REQUEST A DIFFERENT COVERAGE OPTION; EXCEPT THAT SUCH CHANGE SHALL NOT AFFECT ANY CLAIM ARISING OUT OF AN ACCIDENT THAT OCCURRED PRIOR TO THE DATE OF SUCH NOTICE.

**SECTION 5.** Part 7 of article 4 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF THE FOLLOWING NEW SECTIONS to read:

**10-4-706.1. Reduced personal injury protection policy-qualifications.** (1) ON AND AFTER JANUARY 1, 2004, NOTWITHSTANDING ANY PROVISION OF THIS SECTION TO THE CONTRARY, AN INSURER MAY OFFER, AS AN ALTERNATIVE TO THE COVERAGES REQUIRED PURSUANT TO SECTION 10-4-706, TO PERSONS QUALIFIED PURSUANT TO SUBSECTION (3) OF THIS SECTION, A REDUCED PERSONAL INJURY PROTECTION POLICY FOR COMPLIANCE WITH THIS PART 7, WHICH MAY BE A BASIC POLICY PURSUANT TO SECTION 10-4-706.3 OR A MANAGED CARE POLICY PURSUANT TO SECTION 10-4-706.4. ACCEPTANCE OF A POLICY OFFERED PURSUANT TO THIS SECTION SHALL BE VOLUNTARY AND SHALL BE SUBJECT TO ALL REQUIREMENTS OF THIS SECTION.

(2) A PERSON QUALIFIED PURSUANT TO SUBSECTION (3) OF THIS SECTION MAY PURCHASE COVERAGE FOR COMPENSATION WITHOUT REGARD TO FAULT, UP TO A LIMIT OF TWENTY-FIVE THOUSAND DOLLARS PER PERSON FOR ANY ONE MOTOR VEHICLE ACCIDENT, FOR PAYMENT OF ALL REASONABLE EXPENSES FOR MEDICALLY NECESSARY CARE AND TREATMENT PERFORMED WITHIN THREE YEARS AFTER THE MOTOR VEHICLE

ACCIDENT FOR BODILY INJURY ARISING OUT OF A MOTOR VEHICLE ACCIDENT.

(3) (a) TO QUALIFY FOR A REDUCED PERSONAL INJURY PROTECTION POLICY, THE COMBINED ANNUAL GROSS INCOME OF A PERSON APPLYING FOR SUCH A POLICY AND SUCH PERSON'S RESIDENT SPOUSE, IF ANY, SHALL NOT EXCEED ONE HUNDRED EIGHTY-FIVE PERCENT OF THE FEDERAL POVERTY LEVEL FOR A FAMILY OF FOUR, ADJUSTED UPWARD FOR FAMILY SIZE.

(b) ON OR BEFORE JANUARY 1 OF EACH YEAR, THE COMMISSIONER SHALL PRESCRIBE INCOME PROTOCOLS FOR DETERMINING ELIGIBILITY FOR A REDUCED PERSONAL INJURY PROTECTION POLICY BASED UPON THE APPLICABLE FAMILY SIZE INCOME LEVELS CONTAINED IN THE NONFARM INCOME POVERTY PROTOCOLS PRESCRIBED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(c) INCOME VERIFICATION FOR A REDUCED PERSONAL INJURY PROTECTION POLICY SHALL BE THROUGH WRITTEN EVIDENCE FROM THE PERSON SEEKING TO QUALIFY FOR A POLICY ISSUED PURSUANT TO THIS SECTION OF THE ANNUAL GROSS INCOME OF SUCH PERSON AND SUCH PERSON'S RESIDENT SPOUSE FOR THE MOST RECENT TAX YEAR AVAILABLE. SUCH EVIDENCE SHALL BE CONTAINED IN A DOCUMENT ACCEPTABLE TO THE INSURER. FOR PERSONS QUALIFIED PURSUANT TO THIS SUBSECTION (3), EVERY THIRD YEAR FOLLOWING THE DATE UPON WHICH THE POLICY IS ISSUED, THE INSURER SHALL INFORM THE INSURED OF THE INCOME REQUIREMENT ASSOCIATED WITH SUCH POLICY AND MAY REQUEST THE INSURED TO EITHER PROVIDE INCOME VERIFICATION TO THE INSURER OR OPT OUT OF THE REDUCED PERSONAL INJURY PROTECTION COVERAGE IF THE INSURED NO LONGER QUALIFIES.

(4) (a) THE REDUCED PERSONAL INJURY PROTECTION POLICY SHALL APPLY ONLY TO THE NAMED INSURED, RESIDENT SPOUSE, AND RESIDENT CHILDREN. FOR PURPOSES OF THIS SECTION, A CHILD IS A RESIDENT IF SUCH CHILD QUALIFIES AS A DEPENDENT OF THE NAMED INSURED UNDER THE FEDERAL "INTERNAL REVENUE CODE OF 1986", 26 U.S.C. SEC. 151 (c).

(b) ANY PERSON INJURED IN AN ACCIDENT, OTHER THAN THOSE PERSONS WHOSE COVERAGE IS SPECIFICALLY LIMITED TO REDUCED PERSONAL INJURY PROTECTION PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (4), SHALL, IF EXPENSES INCURRED BY SUCH INJURED PERSON EXCEED THE LIMITS OF SUCH REDUCED PERSONAL INJURY PROTECTION POLICY, RECEIVE COVERAGE FOR SUCH EXPENSES OF NOT LESS THAN THE MINIMUM COVERAGE MANDATED BY SECTION 10-4-706.

(5) A PERSON WHO QUALIFIES FOR AND OPTS FOR A REDUCED PERSONAL INJURY PROTECTION POLICY PURSUANT TO THIS SECTION SHALL BE DEEMED IN VIOLATION OF THIS PART 7 IF SUCH PERSON DOES NOT OBTAIN A POLICY PROVIDING LEGAL LIABILITY COVERAGE AS SPECIFIED IN SECTION 10-4-706 (1) (a).

**10-4-706.2. Optional policy types.** (1) THE COVERAGES REQUIRED IN SECTION 10-4-706 OR 10-4-706.1 SHALL BE PROVIDED, AT THE OPTION OF THE NAMED INSURED, THROUGH A BASIC, MANAGED CARE, OR DIRECT ACCESS POLICY OPTION. EACH INSURER SHALL OFFER, AT A MINIMUM, A BASIC POLICY OPTION AND EITHER A MANAGED CARE OR DIRECT ACCESS POLICY OPTION. SUCH POLICY OPTIONS SHALL BE OFFERED TO AN APPLICANT AT THE TIME THE INSURANCE APPLICATION IS TAKEN. THE OFFER SHALL BE IN WRITING OR IN THE SAME MEDIUM IN WHICH THE APPLICATION IS TAKEN. THE INSURER SHALL DISCLOSE THE FOLLOWING

INFORMATION REGARDING THE POLICY OPTIONS AVAILABLE THROUGH THE INSURER, EXPRESSED EITHER AS A DOLLAR SAVINGS OR INCREASE, COMPARED TO THE PREMIUM FOR BASIC PERSONAL INJURY PROTECTION COVERAGE, OR AS A PERCENTAGE OF THE PREMIUM OFFERED BY THE INSURER:

(a) THAT THE APPLICANT IS ENTITLED TO CHOOSE ONE OF THE POLICY OPTIONS AVAILABLE THROUGH THE INSURER, INCLUDING, IN SUMMARY FORM, A DESCRIPTION OF SUCH POLICY OPTIONS;

(b) THE APPROXIMATE COST TO THE APPLICANT FOR EACH OF THE POLICY OPTIONS AVAILABLE THROUGH THE INSURER;

(c) THAT THE APPLICANT SHALL BE DEEMED TO HAVE ELECTED BASIC COVERAGE IF THE APPLICANT FAILS TO ELECT AN OPTION; AND

(d) THAT THE POLICY OPTION CHOSEN BY THE APPLICANT MAY BE CHANGED BY THE NAMED INSURED AT ANY TIME UPON PRIOR NOTICE TO THE INSURER; EXCEPT THAT SUCH CHANGE SHALL NOT AFFECT ANY CLAIM ARISING OUT OF AN ACCIDENT THAT OCCURRED PRIOR TO THE DATE OF SUCH NOTICE.

(2) THE POLICY OPTION ELECTED BY THE APPLICANT SHALL BIND THE NAMED INSURED, RESIDENT SPOUSE, ANY RESIDENT RELATIVE, AND PERSONS OPERATING THE COVERED MOTOR VEHICLE WITH THE PERMISSION OF THE NAMED INSURED OR THE RESIDENT SPOUSE. BASIC COVERAGE SHALL APPLY TO ANY OTHER PERSON ENTITLED TO PERSONAL INJURY PROTECTION COVERAGE UNDER THE POLICY OF INSURANCE.

(3) IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT AN APPLICANT'S CHOICE OF POLICY OPTION PURSUANT TO THIS SECTION BE VOLUNTARY AND THAT NO INSURER SHALL REQUIRE AN INSURED TO AGREE TO A PARTICULAR OPTION OF PROVIDING INSURANCE COVERAGE.

(4) AN INSURER OFFERING THE COVERAGES AUTHORIZED BY THIS SECTION SHALL DEMONSTRATE, IN RATE FILINGS SUBMITTED TO THE COMMISSIONER, THE PREMIUM DIFFERENTIALS FOR EACH OPTION, EXPRESSED EITHER AS A DOLLAR SAVINGS OR INCREASE, COMPARED TO THE PREMIUM FOR BASIC PERSONAL INJURY PROTECTION COVERAGE, OR AS A PERCENTAGE OF THE PREMIUM, AND SHALL FURTHER CERTIFY TO THE COMMISSIONER, PURSUANT TO SECTION 10-4-725, ANY DISCLOSURE LANGUAGE TO BE USED PURSUANT TO SUBSECTION (1) OF THIS SECTION.

**10-4-706.3. Basic policy coverage - participating physicians - referrals - direct access option.** (1) (a) ON AND AFTER JANUARY 1, 2004, EXCEPT FOR EMERGENCY CARE AS PROVIDED IN PARAGRAPH (b) OF SUBSECTION (2) OF THIS SECTION , A PERSON COVERED THROUGH A BASIC COVERAGE POLICY SHALL RECEIVE MEDICALLY NECESSARY CARE AND TREATMENT FROM A PRIMARY PARTICIPATING PHYSICIAN PURSUANT TO SECTION 10-4-706.9. SUCH PRIMARY PARTICIPATING PHYSICIAN MAY REFER OR PRESCRIBE TREATMENT BY ANOTHER PHYSICIAN OR PRACTITIONER AS PROVIDED IN THIS SECTION AND ACCORDING TO THE TREATMENT GUIDELINES ADOPTED PURSUANT TO SECTION 10-4-706.9. ALL MEDICALLY NECESSARY CARE AND TREATMENT BY PARTICIPATING PHYSICIANS OR OTHER PRACTITIONERS BY REFERRAL SHALL ONLY BE PURSUANT TO SUCH TREATMENT GUIDELINES.

(b) EXCEPT AS PROVIDED IN SUBSECTION (3) OF THIS SECTION, REFERRALS FOR MEDICALLY NECESSARY CARE AND TREATMENT FOR BODILY INJURY ARISING FROM A MOTOR VEHICLE ACCIDENT SHALL ONLY BE MADE TO A PHYSICIAN, NURSE PRACTITIONER, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, NEUROPSYCHOLOGIST, PSYCHOLOGIST, CHILD HEALTH ASSOCIATION, PHYSICIAN'S ASSISTANT, SPEECH THERAPIST,

CERTIFIED BIOFEEDBACK THERAPIST, OR PRACTITIONER AS DETERMINED BY THE INSURER PURSUANT TO THE TREATMENT GUIDELINES ADOPTED PURSUANT TO SECTION 10-4-706.9.

(2) (a) A PERSON COVERED THROUGH A BASIC POLICY SHALL OBTAIN ALL MEDICALLY NECESSARY CARE AND TREATMENT FROM A PRIMARY PARTICIPATING PHYSICIAN SELECTED BY THE PERSON, OR THROUGH A REFERRAL FROM THE PRIMARY PARTICIPATING PHYSICIAN, EITHER EXPRESSLY OR BY RECEIVING CARE FROM THE PRIMARY PARTICIPATING PHYSICIAN FOR BODILY INJURY ARISING OUT OF A MOTOR VEHICLE ACCIDENT. FOLLOWING SUCH ACCIDENT, THE INJURED PERSON SHALL BE ENTITLED TO ONE CHANGE OF PRIMARY PARTICIPATING PHYSICIAN, TO A DIFFERENT PRIMARY PARTICIPATING PHYSICIAN, FOR THE CARE AND TREATMENT OF INJURIES. IF THE PERSON REQUESTS A SECOND CHANGE OF PRIMARY PARTICIPATING PHYSICIAN, SUCH CHANGE MAY ONLY OCCUR UPON THE MUTUAL AGREEMENT OF THE INJURED PERSON AND THE INSURER.

(b) NO DEDUCTIBLE OR COINSURANCE COVERED UNDER A BASIC COVERAGE POLICY SHALL BE APPLIED WITH RESPECT TO CARE, TREATMENT, SERVICES, PRODUCTS, OR ACCOMMODATION PROVIDED TO OR EXPENSES INCURRED BY AN INSURED DURING THE FIRST TWENTY-FOUR HOURS IN WHICH EMERGENCY TREATMENT HAS BEEN PROVIDED OR UNTIL THE INSURED PERSON'S EMERGENCY MEDICAL CONDITION IS STABILIZED, WHICHEVER IS LONGER, OR UNTIL THE INSURED PERSON IS TRANSFERRED TO A PARTICIPATING PROVIDER IN ACCORDANCE WITH APPLICABLE LAW.

(3) EVERY INSURER OFFERING A BASIC POLICY PURSUANT TO THIS SECTION SHALL MAKE AVAILABLE, FOR AN ADDITIONAL PREMIUM, AND SHALL PROVIDE, AT THE OPTION OF THE NAMED INSURED, ADDITIONAL

COVERAGE FOR PAYMENT OF BENEFITS FOR DIRECT ACCESS TO A PARTICIPATING CHIROPRACTOR AND SUCH OTHER PRACTITIONERS AS DETERMINED BY THE INSURER. SUCH DIRECT ACCESS SHALL SPECIFY THAT TREATMENT BY SUCH CHIROPRACTOR AND ANY OTHER PRACTITIONER SHALL BE PURSUANT TO THE TREATMENT GUIDELINES AND SHALL SPECIFY ANY OTHER LIMITATION OF COVERAGE TO THE NAMED INSURED.

**10-4-706.4. Managed care policy coverage.** (1) ON AND AFTER JANUARY 1, 2004, A PERSON COVERED THROUGH A MANAGED CARE POLICY SHALL RECEIVE MEDICALLY NECESSARY CARE AND TREATMENT FROM A PRIMARY PARTICIPATING PHYSICIAN OR CHIROPRACTOR REGISTERED PURSUANT TO SECTION 10-4-706.9, THROUGH A MANAGED CARE ARRANGEMENT SUCH AS A HEALTH MAINTENANCE ORGANIZATION OR A PREFERRED PROVIDER ORGANIZATION. THE PRIMARY PARTICIPATING PHYSICIAN OR CHIROPRACTOR MAY REFER OR PRESCRIBE TREATMENT BY ANOTHER PHYSICIAN OR PRACTITIONER, AS APPROPRIATE, ACCORDING TO THE TREATMENT GUIDELINES ADOPTED PURSUANT TO SECTION 10-4-706.9. ALL CARE AND TREATMENT BY PARTICIPATING PHYSICIANS OR CHIROPRACTOR OR OTHER PRACTITIONERS BY REFERRAL SHALL BE PURSUANT TO THE TREATMENT GUIDELINES AND REQUIREMENTS OF THE MANAGED CARE ARRANGEMENT.

(2) (a) AN INSURER MAY MAKE DEDUCTIBLES AND COINSURANCE OPTIONS AVAILABLE, INCLUDING, BUT NOT LIMITED TO, MAKING AVAILABLE AND PROVIDING, AT THE OPTION OF THE NAMED INSURED AND FOR AN INCREASED PREMIUM, ADDITIONAL COVERAGE FOR THE DIRECT ACCESS TO ACCREDITED PROVIDERS, WHO SHALL RENDER TREATMENT ONLY PURSUANT TO THE TREATMENT GUIDELINES AND IN ACCORDANCE OF THE MANAGED CARE ARRANGEMENT, IN SUCH AMOUNT AND PERCENTAGES

AS SUCH INSURER MAY DETERMINE, AND AN INSURER MAY MAKE OTHER SERVICES, CONDITIONS, AND LIMITATIONS TO COVERAGE AVAILABLE.

(b) NO DEDUCTIBLE OR COINSURANCE COVERED UNDER A POLICY SHALL BE APPLIED WITH RESPECT TO CARE, TREATMENT, SERVICES, PRODUCTS, OR ACCOMMODATION PROVIDED TO OR EXPENSES INCURRED BY AN INSURED DURING THE FIRST TWENTY-FOUR HOURS IN WHICH EMERGENCY TREATMENT HAS BEEN PROVIDED OR UNTIL THE INSURED PERSON'S EMERGENCY MEDICAL CONDITION IS STABILIZED, WHICHEVER IS LONGER, OR UNTIL THE INSURED PERSON IS TRANSFERRED TO A MANAGED CARE PROVIDER IN ACCORDANCE WITH APPLICABLE LAW.

**10-4-706.6. Direct access policy coverage.** ON AND AFTER JANUARY 1, 2004, A PERSON COVERED THROUGH A DIRECT ACCESS POLICY MAY RECEIVE MEDICALLY NECESSARY CARE AND TREATMENT FROM ANY HEALTH CARE PROVIDER WITHOUT REGARD TO PARTICIPATING PROVIDER REQUIREMENTS AND WITHOUT REGARD TO REFERRAL OR PRESCRIPTION FROM A PARTICIPATING PHYSICIAN. COVERAGE FOR CARE AND TREATMENT PROVIDED TO A PERSON UNDER A DIRECT ACCESS POLICY SHALL ONLY INCLUDE CARE AND TREATMENT THAT IS MEDICALLY NECESSARY. THE MEDICAL NECESSITY OF SUCH CARE AND TREATMENT SHALL BE PRESUMPTIVELY DETERMINED BASED UPON THE TREATMENT GUIDELINES ADOPTED PURSUANT TO SECTION 10-4-706.9 AND SUBJECT TO DETERMINATION BY INTERNAL AND EXTERNAL REVIEW PURSUANT TO SECTIONS 10-4-725.1 OR 10-4-725.2. AN INSURER MAY LIMIT COVERAGE TO ONLY LICENSED, REGISTERED, OR CERTIFIED HEALTH CARE PROVIDERS.

**10-4-706.7. Care and treatment for persons under thirteen years of age.** (1) ON AND AFTER JANUARY 1, 2004, ANY PERSON WHO IS ENTITLED TO COVERAGE UNDER SECTION 10-4-706 OR 10-4-706.1 AND IS

LESS THAN THIRTEEN YEARS OF AGE WHEN THE MOTOR VEHICLE ACCIDENT NECESSITATING SUCH BENEFITS OCCURS SHALL BE SUBJECT TO THE PROVISIONS OF THIS SECTION.

(2) WITHIN THREE YEARS AFTER THE DATE OF THE ACCIDENT, A PHYSICIAN MAY RENDER A WRITTEN OPINION, BASED ON A REASONABLE DEGREE OF MEDICAL PROBABILITY AND SUPPORTED BY DETAILED AND DESCRIPTIVE OBJECTIVE EVIDENCE AND REFERENCE TO APPLICABLE TREATMENT GUIDELINES, THAT A MEDICALLY NECESSARY SURGERY OR RECONSTRUCTIVE PROCEDURE CANNOT BE PROVIDED TO THE CLAIMANT WITHIN THREE YEARS AFTER THE DATE OF THE ACCIDENT BECAUSE OF SUCH PERSON'S STATUS OF JUVENILE GROWTH AND LACK OF PHYSICAL MATURITY. IF SUCH OPINION IS RENDERED, BENEFITS SHALL BE PAID IN THE FUTURE WHEN EXPENSES ARE INCURRED FOR SUCH SURGERY OR RECONSTRUCTIVE PROCEDURE, UNLESS A DETERMINATION IS MADE UNDER THIS SECTION BEFORE SUCH SURGERY OR RECONSTRUCTIVE PROCEDURE OCCURS THAT IT IS NO LONGER MEDICALLY NECESSARY OR THAT THE NEED FOR SUCH SURGERY OR RECONSTRUCTIVE PROCEDURE WAS NOT CAUSED BY THE MOTOR VEHICLE ACCIDENT. ANY BENEFITS PAYMENT FOR A MEDICALLY NECESSARY SURGERY OR RECONSTRUCTIVE PROCEDURE THAT AROSE OUT OF A MOTOR VEHICLE ACCIDENT SHALL BE SUBJECT TO THE LIMITS OF COVERAGE IN FORCE AT THE TIME OF SUCH ACCIDENT. SUCH TREATMENT AND EXPENSES SHALL BE COMPENSATED AS IF THEY WERE PERFORMED WITHIN THREE YEARS AFTER THE ACCIDENT IF THEY ARE ACTUALLY INCURRED BEFORE THE CLAIMANT ATTAINS EIGHTEEN YEARS OF AGE. THIS SECTION APPLIES ONLY TO SURGERY OR RECONSTRUCTIVE PROCEDURES OCCURRING THREE YEARS OR MORE AFTER A MOTOR VEHICLE ACCIDENT, INCLUDING EXPENSES FOR MEDICAL, HOSPITAL, AND NURSING

SERVICES AND DIAGNOSTIC PROCEDURES SPECIFICALLY RELATED THERETO.

(3) NO LATER THAN NINETY DAYS BEFORE A FUTURE SURGERY OR RECONSTRUCTIVE PROCEDURE IS SCHEDULED TO OCCUR, THE CLAIMANT OR HIS OR HER REPRESENTATIVE OR THE PROVIDER WHO INTENDS TO PERFORM THE SURGERY OR RECONSTRUCTIVE PROCEDURE SHALL NOTIFY THE INSURER IN WRITING OF THE SURGERY OR RECONSTRUCTIVE PROCEDURE. SUCH WRITTEN NOTICE SHALL INCLUDE THE DATE OF THE MOTOR VEHICLE ACCIDENT, THE CLAIM NUMBER, IF ANY WAS ASSIGNED BY THE INSURER, A DESCRIPTION OF THE PROPOSED TREATMENT, THE DIAGNOSIS OR PROGNOSIS, THE DATE THE TREATMENT IS SCHEDULED TO BEGIN, AND THE NAME, ADDRESS, TELEPHONE NUMBER, AND SPECIALTY OF THE PROVIDER. THE INSURER MAY REQUEST AN EXTERNAL REVIEW BE CONDUCTED PURSUANT TO SECTION 10-4-725.2 TO DETERMINE IF SUCH SURGERY OR RECONSTRUCTIVE PROCEDURE IS MEDICALLY NECESSARY AND AROSE OUT OF THE USE AND OPERATION OF A MOTOR VEHICLE.

(4) ANY FUTURE SURGERY OR RECONSTRUCTIVE PROCEDURE THAT IS PAID ON BEHALF OF A CLAIMANT UNDER THIS SECTION SHALL BE IN ADDITION TO ANY MEDICAL BENEFITS PAID FOR TREATMENT AND EXPENSES INCURRED WITHIN THREE YEARS AFTER THE ACCIDENT, SUBJECT TO APPLICABLE COVERAGE LIMITS IN FORCE AT THE TIME OF THE ACCIDENT.

(5) THE TREATING PROVIDER SHALL MAINTAIN THE ORIGINALS OF ALL MEDICAL REPORTS, OFFICE NOTES, TESTS, X RAYS, DIAGNOSTIC STUDIES, AND ALL OTHER RECORDS OF ANY KIND IN SUCH PROVIDER'S FILE UNTIL THE CLAIMANT IS EIGHTEEN YEARS OF AGE. THE PROVIDER OR THE PROVIDER'S SUCCESSOR IN INTEREST SHALL PRODUCE UPON WRITTEN REQUEST ALL SUCH DOCUMENTS, OR COPIES THEREOF, AS APPROPRIATE, TO ANY SUBSEQUENT PROVIDER TREATING THE CLAIMANT, AN ACCREDITED

PHYSICIAN PERFORMING AN EXTERNAL REVIEW PURSUANT TO SECTION 10-4-725.2, OR AN INSURER.

(6) ANY COVERAGE PROVIDED UNDER THIS SECTION SHALL BE SUBJECT TO ALL PROVISIONS OF THE UNDERLYING INSURANCE POLICY, INCLUDING ANY MANAGED CARE ARRANGEMENTS.

(7) AN INSURER SHALL NOT BE REQUIRED TO MAINTAIN A PERSONAL INJURY PROTECTION CLAIM FILE LONGER THAN IS REQUIRED BY APPLICABLE LAW UNLESS THE CLAIM FILE CONTAINS A WRITTEN OPINION RECEIVED BY THE INSURER WITHIN THREE YEARS AFTER THE DATE OF THE MOTOR VEHICLE ACCIDENT, PURSUANT TO SUBSECTION (2) OF THIS SECTION. ANY INSURER THAT RECEIVES SUCH A WRITTEN OPINION SHALL MAINTAIN SUCH CLAIM FILE UNTIL THE CLAIMANT RECEIVES THE NECESSARY SURGERY OR RECONSTRUCTIVE PROCEDURE OR ATTAINS EIGHTEEN YEARS OF AGE, WHICHEVER OCCURS FIRST.

**10-4-706.8. Optional coverages for wage loss and essential services.** (1) ON AND AFTER JANUARY 1, 2004, EACH INSURER OFFERING COVERAGE UNDER THIS PART 7 SHALL MAKE AVAILABLE, AND SHALL PROVIDE AT THE OPTION OF THE NAMED INSURED, COVERAGE FOR PAYMENT EQUIVALENT TO ONE HUNDRED PERCENT OF THE FIRST ONE HUNDRED TWENTY-FIVE DOLLARS OF LOSS OF GROSS INCOME PER WEEK, SEVENTY PERCENT OF THE NEXT ONE HUNDRED TWENTY-FIVE DOLLARS OF LOSS OF GROSS INCOME PER WEEK, AND SIXTY PERCENT OF ANY LOSS OF GROSS INCOME PER WEEK IN EXCESS THEREOF, WITH THE TOTAL COVERAGE UNDER THIS SUBSECTION (1) NOT EXCEEDING FOUR HUNDRED DOLLARS PER WEEK, FROM WORK THE INJURED PERSON WOULD HAVE PERFORMED HAD HE OR SHE NOT BEEN INJURED DURING A PERIOD COMMENCING THE DAY AFTER THE DATE OF THE ACCIDENT, AND NOT EXCEEDING FIFTY-TWO

ADDITIONAL WEEKS.

(2) (a) ON AND AFTER JANUARY 1, 2004, IN ADDITION, EACH INSURER OFFERING COVERAGE PURSUANT TO THIS PART 7 SHALL MAKE AVAILABLE, AND SHALL PROVIDE AT THE OPTION OF THE NAMED INSURED, COVERAGE FOR PAYMENT OF EXPENSES NOT EXCEEDING TWENTY-FIVE DOLLARS PER DAY THAT ARE REASONABLY INCURRED FOR ESSENTIAL SERVICES IN LIEU OF THOSE ACTIVITIES THE INJURED PERSON WOULD HAVE OTHERWISE PERFORMED WITHOUT ASSISTANCE DURING THE PERIOD COMMENCING THE DAY AFTER THE DATE OF THE MOTOR VEHICLE ACCIDENT AND NOT EXCEEDING FIFTY-TWO ADDITIONAL WEEKS.

(b) COVERAGE FOR ESSENTIAL SERVICES OFFERED PURSUANT TO THIS SUBSECTION (2) SHALL NOT BE PAYABLE TO A RESIDENT RELATIVE OF THE INJURED PERSON OR FOR GRATUITOUSLY PROVIDED ESSENTIAL SERVICES.

(3) THE OPTIONAL COVERAGE SPECIFIED IN THIS SECTION SHALL NOT ACCRUE FOLLOWING THE DEATH OF THE INJURED PERSON.

**10-4-725.1. Procedure for denial of benefits.** (1) ON AND AFTER JANUARY 1, 2004, AN INSURER SHALL ESTABLISH PROCEDURES FOR INTERNAL REVIEW OF DENIAL OF A CLAIM FOR COVERED BENEFITS UNDER SECTION 10-4-706 OR 10-4-706.1, BASED ON THE MEDICAL NECESSITY OF THE TREATMENT. SUCH PROCEDURES SHALL INCLUDE PROVISIONS FOR AN EXPEDITED INTERNAL REVIEW. THE INTERNAL REVIEW PROCEDURES SHALL BE FILED WITH THE COMMISSIONER AND SHALL SET FORTH THE PROCEDURES TO DETERMINE WHETHER A CLAIM FOR BENEFITS UNDER THE REQUIREMENTS OF SECTION 10-4-706 OR 10-4-706.1 IS MEDICALLY NECESSARY. THE INJURED PERSON, THE PROVIDER, AND THE INSURER SHALL COMPLY WITH THE REQUIREMENTS OF THE REVIEW PROCESS,

INCLUDING ANY REQUIREMENT THAT THE INJURED PERSON EXECUTE A RELEASE OF MEDICAL INFORMATION TO PROVIDE ALL THE INSURED'S MEDICAL RECORDS RELEVANT TO THE BODILY INJURY ARISING OUT OF THE MOTOR VEHICLE ACCIDENT AND RECORDS FOR ANY RELEVANT PRIOR PHYSICAL OR MENTAL CONDITION.

(2) THE INTERNAL REVIEW SHALL BE COMPLETED NO LATER THAN FORTY-FIVE DAYS AFTER THE REQUEST FOR REVIEW. THE FINDINGS AND CONCLUSIONS SHALL BE BINDING ON THE INJURED PERSON AND THE INSURER, UNLESS EITHER THE INJURED PERSON OR INSURER REQUESTS AN EXTERNAL REVIEW. THE PARTY REQUESTING EXTERNAL REVIEW SHALL NOTIFY THE OTHER PARTY AND SUCH NOTICE MUST BE RECEIVED NO LATER THAN FIFTEEN DAYS AFTER THE DATE OF THE INTERNAL REVIEW DETERMINATION OR THE RIGHT TO AN EXTERNAL REVIEW SHALL BE DEEMED WAIVED.

(3) AN INSURER'S DENIAL OF A CLAIM FOR BENEFITS SHALL:

(a) BE IN WRITING AND SET FORTH THE REASONS FOR THE DENIAL BASED ON THE MEDICAL NECESSITY OF THE TREATMENT AND THE TREATMENT GUIDELINES; AND

(b) ADVISE THE INJURED PERSON OF THE RIGHT TO APPEAL SUCH DENIAL AND THE TIME FRAMES FOR SUCH APPEALS.

(4) NOTHING IN THIS SECTION SHALL BE DEEMED TO PREVENT AN INSURER FROM DETERMINING THAT THE BODILY INJURY WAS NOT CAUSED, IN WHOLE OR IN PART, BY THE SUBJECT MOTOR VEHICLE ACCIDENT OR THAT THE EXPENSES FOR TREATMENT AND SERVICES WERE NOT REASONABLE AS OTHERWISE PROVIDED IN THIS PART 7.

**10-4-725.2. External review of benefit denials - definitions.** (1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE

REQUIRES:

(a) "EXPEDITED REVIEW" MEANS A REVIEW, FOLLOWING COMPLETION OF PROCEDURES FOR INTERNAL REVIEW PURSUANT TO SECTION 10-4-725.1, OF AN ADVERSE DETERMINATION INVOLVING A SITUATION WHERE ADHERENCE TO THE TIME PERIODS SPECIFIED FOR THE STANDARD INDEPENDENT EXTERNAL REVIEW PROCEDURES WOULD SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE INSURED OR WOULD JEOPARDIZE THE INSURED'S ABILITY TO GAIN MAXIMUM MEDICAL IMPROVEMENT.

(b) (I) "EXPERT REVIEWER" MEANS A PARTICIPATING PHYSICIAN ASSIGNED BY THE PROGRAM MANAGER TO CONDUCT AN INDEPENDENT EXTERNAL REVIEW. AN EXPERT REVIEWER SHALL NOT:

(A) HAVE BEEN INVOLVED IN THE INSURED'S CARE PREVIOUSLY;

(B) BE A MEMBER OF THE BOARD OF DIRECTORS OF THE INSURER;

(C) HAVE BEEN PREVIOUSLY INVOLVED IN THE REVIEW PROCESS FOR THE INSURED SEEKING EXTERNAL REVIEW;

(D) HAVE A DIRECT FINANCIAL INTEREST IN THE CASE OR IN THE OUTCOME OF THE REVIEW; NOR

(E) BE AN EMPLOYEE OF THE INSURER.

(II) AN EXPERT REVIEWER SHALL:

(A) BE AN EXPERT IN THE TREATMENT OF THE MEDICAL CONDITION OF THE INSURED WHOSE BODILY INJURY IS THE SUBJECT OF THE REVIEW AND SHALL BE KNOWLEDGEABLE ABOUT THE TREATMENT GUIDELINES ADOPTED UNDER SECTION 10-4-706.9 AND THE SERVICE THAT IS THE SUBJECT OF THE REVIEW THROUGH THE EXPERT'S ACTUAL, CURRENT CLINICAL EXPERIENCE;

(B) HOLD A LICENSE ISSUED BY A STATE AND A CURRENT

CERTIFICATION BY A RECOGNIZED AMERICAN MEDICAL OR CHIROPRACTIC SPECIALTY BOARD IN THE AREA APPROPRIATE TO THE SUBJECT OF REVIEW; AND

(C) HAVE NO HISTORY OF CONFIRMED DISCIPLINARY ACTION OR SANCTION, INCLUDING LOSS OF STAFF PRIVILEGES OR PARTICIPATION RESTRICTIONS, TAKEN BY ANY HOSPITAL, GOVERNMENT, OR REGULATORY BODY; EXCEPT THAT A LETTER OF ADMONITION SHALL NOT BE CONSIDERED A DISCIPLINARY ACTION OR SANCTION.

(2) THE PROGRAM MANAGER SHALL ESTABLISH AN EXTERNAL REVIEW PROCESS THAT MEETS THE REQUIREMENTS OF THIS SECTION. THE REASONABLE COST OF AN EXTERNAL REVIEW SHALL BE PAID BY THE PARTY REQUESTING THE EXTERNAL REVIEW.

(3) THE INSURER SHALL ADVISE THE ELIGIBLE INJURED PERSON IN WRITING OF THE AVAILABILITY OF THE INTERNAL REVIEW PROCESS UNDER SECTION 10-4-725.1 AND OF THE EXTERNAL REVIEW PROCESS, THE CIRCUMSTANCES UNDER WHICH AN ELIGIBLE INJURED PERSON REQUESTING AN EXTERNAL REVIEW MAY USE THE EXTERNAL REVIEW PROCESS, THE PROCEDURES FOR REQUESTING AN EXTERNAL REVIEW, AND THE DEADLINES ASSOCIATED WITH AN EXTERNAL REVIEW.

(4) THE ELIGIBLE INJURED PERSON OR INSURER REQUESTING AN EXTERNAL REVIEW SHALL MAKE SUCH REQUEST WITHIN SIXTY CALENDAR DAYS AFTER RECEIVING NOTIFICATION OF DETERMINATION OF INTERNAL REVIEW PURSUANT TO SECTION 10-4-725.1. SUCH NOTIFICATION OF THE DETERMINATION SHALL INCLUDE A NOTIFICATION OF THE RIGHT TO AN EXTERNAL REVIEW AND THE TIME FRAMES FOR REQUESTING SUCH REVIEW. THE ELIGIBLE INJURED PERSON OR INSURER REQUESTING AN EXTERNAL REVIEW SHALL SPECIFY WHETHER THE REQUEST IS FOR AN EXPEDITED

REVIEW.

(5) (a) THE INSURER SHALL PROVIDE TO THE EXTERNAL REVIEWER COPIES OF THE FOLLOWING DOCUMENTS:

(I) ANY INFORMATION SUBMITTED TO THE INSURER BY AN ELIGIBLE INJURED PERSON REQUESTING AN EXTERNAL REVIEW, OR BY THE PROVIDER OF AN ELIGIBLE INJURED PERSON SEEKING AN EXTERNAL REVIEW, IN SUPPORT OF THE REQUEST. THE EXTERNAL REVIEWER SHALL MAINTAIN THE CONFIDENTIALITY OF ANY MEDICAL RECORDS SUBMITTED PURSUANT TO THIS SUBSECTION (5).

(II) A COPY OF ANY RELEVANT DOCUMENTS USED BY THE INSURER TO DETERMINE THE MEDICAL NECESSITY OR CONFORMITY WITH THE TREATMENT GUIDELINES ADOPTED BY THE PROGRAM MANAGER PURSUANT TO SECTION 10-4-706.9, A COPY OF ANY DENIAL LETTERS ISSUED BY THE INSURER CONCERNING THE INDIVIDUAL CASE UNDER REVIEW, AND A COPY OF THE DETERMINATION. THE INSURER SHALL PROVIDE TO AN ELIGIBLE INJURED PERSON, UPON THE ELIGIBLE INJURED PERSON'S REQUEST FOR AN EXTERNAL REVIEW, ALL RELEVANT INFORMATION SUPPLIED TO THE EXTERNAL REVIEWER THAT IS NOT CONFIDENTIAL OR PRIVILEGED UNDER STATE OR FEDERAL LAW CONCERNING THE INDIVIDUAL CASE UNDER REVIEW.

(b) THE EXTERNAL REVIEWER SHALL NOTIFY THE ELIGIBLE INJURED PERSON, THE ELIGIBLE INJURED PERSON'S PROVIDER, AND THE INSURER OF ANY ADDITIONAL MEDICAL INFORMATION REQUIRED TO CONDUCT THE REVIEW. THE ELIGIBLE INJURED PERSON OR THE ELIGIBLE INJURED PERSON'S PROVIDER SHALL THEN SUBMIT THE ADDITIONAL INFORMATION TO THE EXTERNAL REVIEWER AND THE INSURER. THE INSURER MAY, AT ITS DISCRETION, DETERMINE THAT ADDITIONAL INFORMATION PROVIDED BY

THE ELIGIBLE INJURED PERSON OR THE ELIGIBLE INJURED PERSON'S PROVIDER JUSTIFIES A RECONSIDERATION OF ITS DENIAL OF COVERAGE, AND A SUBSEQUENT DECISION BY THE INSURER TO PROVIDE COVERAGE SHALL TERMINATE THE EXTERNAL REVIEW UPON NOTIFICATION IN WRITING TO THE EXTERNAL REVIEWER AND THE ELIGIBLE INJURED PERSON.

(6) (a) THE EXTERNAL REVIEWER SHALL SUBMIT THE EXPERT DETERMINATION TO THE INSURER, THE ELIGIBLE INJURED PERSON, AND THE ELIGIBLE INJURED PERSON'S PROVIDER WITHIN THIRTY WORKING DAYS AFTER THE INSURER HAS RECEIVED A REQUEST FOR EXTERNAL REVIEW; EXCEPT THAT, AT THE REQUEST OF THE EXPERT REVIEWER, SUCH DEADLINE SHALL BE EXTENDED BY UP TO TEN WORKING DAYS FOR THE CONSIDERATION OF ADDITIONAL INFORMATION REQUIRED PURSUANT TO THIS SECTION. IN THE CASE OF AN EXPEDITED REVIEW, THE EXPERT DETERMINATION SHALL BE SUBMITTED WITHIN SEVEN WORKING DAYS AFTER THE INSURER HAS RECEIVED A REQUEST FOR EXTERNAL REVIEW; EXCEPT THAT, AT THE REQUEST OF THE EXPERT REVIEWER, THE DEADLINE SHALL BE EXTENDED FOR FIVE WORKING DAYS FOR THE CONSIDERATION OF ADDITIONAL INFORMATION REQUIRED PURSUANT TO THIS SECTION.

(b) THE EXPERT REVIEWER'S DETERMINATION SHALL BE IN WRITING AND SHALL STATE WHY THE SERVICE IS OR IS NOT COVERED. THE EXPERT REVIEWER'S DETERMINATION SHALL SPECIFICALLY CITE THE RELEVANT PROVISIONS IN THE TREATMENT GUIDELINES ADOPTED BY THE PROGRAM MANAGER PURSUANT TO SECTION 10-4-706.9, THE SPECIFIC MEDICAL CONDITION OF THE ELIGIBLE INJURED PERSON, AND THE RELEVANT DOCUMENTS PROVIDED PURSUANT TO THIS SECTION TO SUPPORT THE EXPERT REVIEWER'S DETERMINATION. THE EXPERT REVIEWER'S DETERMINATION SHALL BE BASED ON AN OBJECTIVE REVIEW OF RELEVANT

TREATMENT GUIDELINES AND THE MEDICAL NECESSITY STANDARDS SET FORTH IN SECTION 10-4-706 OR 10-4-706.1.

(c) A DETERMINATION SHALL ALSO INCLUDE:

(I) THE TITLES AND QUALIFYING CREDENTIALS OF THE PERSON CONDUCTING THE REVIEW;

(II) A STATEMENT OF THE UNDERSTANDING OF THE PERSON CONDUCTING THE REVIEW OF THE NATURE OF THE GRIEVANCE AND ALL PERTINENT FACTS;

(III) THE RATIONALE FOR THE DECISION;

(IV) REFERENCE TO THE RELEVANT TREATMENT GUIDELINES, MEDICAL AND SCIENTIFIC EVIDENCE, AND DOCUMENTATION CONSIDERED IN MAKING THE DETERMINATION; AND

(V) IN CASES INVOLVING A DETERMINATION ADVERSE TO THE ELIGIBLE INJURED PERSON, THE INSTRUCTIONS FOR REQUESTING A WRITTEN STATEMENT OF THE CLINICAL RATIONALE, INCLUDING THE CLINICAL REVIEW CRITERIA USED TO MAKE THE DETERMINATION.

(7) THE DETERMINATION OF THE EXPERT REVIEWER SHALL BE BINDING ON THE INSURER AND ON THE ELIGIBLE INJURED PERSON, UNLESS APPEALED TO A COURT OF APPROPRIATE JURISDICTION WITHIN NINETY DAYS AFTER THE DETERMINATION IN ACCORDANCE WITH THIS SECTION.

(8) WHERE AN EXPERT DETERMINATION IS MADE IN FAVOR OF THE ELIGIBLE INJURED PERSON, COVERAGE FOR THE TREATMENT AND SERVICES REQUIRED UNDER THIS SECTION SHALL BE PROVIDED SUBJECT TO THIS PART 7.

(9) AN EXPERT REVIEWER SHALL BE IMMUNE FROM CIVIL LIABILITY IN ANY ACTION BROUGHT BY ANY PERSON BASED UPON THE DETERMINATIONS MADE PURSUANT TO THIS SECTION. THIS SUBSECTION (9)

SHALL NOT APPLY TO AN ACT OR OMISSION OF THE EXPERT REVIEWER THAT IS MADE IN BAD FAITH OR INVOLVES GROSS NEGLIGENCE.

(10) NOTHING IN THIS SECTION SHALL MAKE THE INSURER LIABLE FOR DAMAGES ARISING FROM ANY ACT OR OMISSION OF THE EXPERT REVIEWER.

**SECTION 6.** Part 7 of article 4 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

**10-4-706.9. Commissioner to contract for program manager - duties of program manager - participating practitioner program - treatment guidelines.** (1) (a) NO LATER THAN AUGUST 30, 2003, THE COMMISSIONER SHALL CONTRACT FOR A PROGRAM MANAGER FOR THE DEVELOPMENT AND IMPLEMENTATION OF TREATMENT GUIDELINES, A PARTICIPATION PROGRAM FOR PRACTITIONERS SEEKING TO PROVIDE CARE AND TREATMENT PURSUANT TO THIS PART 7, AND AN EXTERNAL APPEALS PROCESS REGARDING DISPUTES RELATED TO THE DENIAL OF CLAIMS FOR BENEFITS UNDER THIS PART 7, AND FOR THE IMPLEMENTATION OF THE PROVISIONS OF HOUSE BILL 03-1225. IN DEVELOPING TREATMENT GUIDELINES, A PARTICIPATING PRACTITIONER PROGRAM, AND AN EXTERNAL APPEALS PROCESS, THE PROGRAM MANAGER SHALL CONSULT WITH THE EXECUTIVE DIRECTOR OF THE DIVISION OF WORKERS' COMPENSATION WITHIN THE DEPARTMENT OF LABOR AND EMPLOYMENT AND THE HEALTH CARE PROVIDER COMMUNITY. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO AFFECT THE AUTHORITY OF THE COMMISSIONER TO OVERSEE THE ACTIVITIES OF THE PROGRAM MANAGER OR THE ENFORCEMENT OF THE PROVISIONS OF THIS PART 7.

(b) THE COMMISSIONER SHALL, THROUGH A NEGOTIATED

CONTRACT, SELECT A PROGRAM MANAGER TO SERVE AS THE MANAGING ENTITY FOR THE PARTICIPATING PRACTITIONER PROGRAM AND THE APPEALS PROCESS REGARDING DISPUTES RELATED TO THE DENIAL OF CLAIMS FOR BENEFITS. THE PROGRAM MANAGER SHALL BE A DOMESTIC NONPROFIT CORPORATION THAT IS EXPERIENCED IN DETERMINATIONS OF MEDICAL NECESSITY AND CONDUCTING UTILIZATION REVIEW FOR THE STATE'S MEDICAL ASSISTANCE PROGRAM DESCRIBED IN ARTICLE 4 OF TITLE 26, C.R.S.

(c) THE COMMISSIONER MAY CONTRACT WITH A PROGRAM MANAGER FOR A PERIOD OF NOT MORE THAN THREE YEARS, SUBJECT TO REMOVAL FOR CAUSE. AT LEAST ONE YEAR PRIOR TO THE EXPIRATION OF EACH CONTRACT PERIOD, THE COMMISSIONER SHALL INVITE ALL INTERESTED PARTIES, INCLUDING THE CURRENT PROGRAM MANAGER, TO SUBMIT BIDS TO SERVE AS THE MANAGING ENTITY FOR THE SUCCEEDING CONTRACT PERIOD. SELECTION OF THE PROGRAM MANAGER FOR THE SUCCEEDING PERIOD SHALL BE MADE AT LEAST SIX MONTHS PRIOR TO THE END OF THE CURRENT PERIOD.

(2) (a) THE TREATMENT GUIDELINES DEVELOPED BY THE PROGRAM MANAGER SHALL INCORPORATE THE MEDICAL TREATMENT GUIDELINES AND UTILIZATION STANDARDS USED BY THE DIVISION OF WORKERS' COMPENSATION WITHIN THE DEPARTMENT OF LABOR AND EMPLOYMENT; EXCEPT THAT THE PROVISIONS RELATED TO IMPAIRMENT RATINGS SHALL NOT BE INCORPORATED. SUCH TREATMENT GUIDELINES SHALL BE SUPPLEMENTED OR AMENDED BY THE PROGRAM MANAGER TO ADDRESS CONDITIONS SPECIFIC TO INJURIES OR PERSONS NOT OTHERWISE CONSIDERED IN WORKERS' COMPENSATION GUIDELINES. THE PROGRAM MANAGER SHALL DEVELOP AND RECOMMEND POLICIES TO THE

COMMISSIONER CONCERNING REPORTING REQUIREMENTS, PENALTIES FOR FAILURE TO REPORT CORRECTLY OR IN A TIMELY MANNER, UTILIZATION CONTROL REQUIREMENTS FOR SERVICES, AND THE PARTICIPATING PRACTITIONER PROGRAM PROVIDED UNDER THIS SECTION.

(b) THE PROGRAM MANAGER SHALL ENTER INTO CONTRACTS WITH PARTICIPATING PROVIDERS FOR THE PURPOSES OF THE PARTICIPATING PRACTITIONER PROGRAM. SUCH CONTRACTS SHALL INCLUDE A PROVISION FOR THE TERMINATION OF THE CONTRACT FOR FAILURE TO FOLLOW AND APPLY THE MEDICAL GUIDELINES ADOPTED PURSUANT TO THIS SECTION.

(c) THE COMMISSIONER SHALL ADOPT BY RULE THE TREATMENT GUIDELINES AND PARTICIPATING PRACTITIONER PROGRAM DEVELOPED BY THE PROGRAM MANAGER AS THE COMMISSIONER DEEMS APPROPRIATE. THE TREATMENT GUIDELINES AND PARTICIPATING PRACTITIONER PROGRAM SHALL BE SUBMITTED TO THE COMMISSIONER NO LATER THAN NOVEMBER 1, 2003. ON AND AFTER JANUARY 1, 2004, SUCH TREATMENT GUIDELINES SHALL BE USED BY HEALTH CARE PROVIDERS IN THE PARTICIPATING PRACTITIONER PROGRAM FOR THE MEDICALLY NECESSARY CARE AND TREATMENT OF INSURED PERSONS AS REQUIRED UNDER THIS PART 7.

(3) (a) THE PROGRAM MANAGER SHALL ADOPT A PARTICIPATING PRACTITIONER PROGRAM, WHICH SHALL INCLUDE A PROGRAM ESTABLISHING THE ACCREDITATION REQUIREMENTS FOR PHYSICIANS AND OTHER PRACTITIONERS WHO PROVIDE PRIMARY CARE TO INJURED PERSONS FOR BODILY INJURY ARISING OUT OF A MOTOR VEHICLE ACCIDENT.

(b) A PHYSICIAN WHO PROVIDES THERAPEUTIC TREATMENT TO AN INJURED PERSON SHALL HAVE COMPLETED ALL REQUIREMENTS FOR, AND ACTUALLY RECEIVED, ACCREDITATION; EXCEPT THAT PHYSICIANS WHO PROVIDE EMERGENCY CARE FOLLOWING A MOTOR VEHICLE ACCIDENT AND

SPECIALISTS WHO DO NOT RENDER PRIMARY CARE TO INSURED PERSONS DO NOT REQUIRE ACCREDITATION. THE FACILITY WHERE A PHYSICIAN PROVIDES SUCH SERVICES CANNOT BE ACCREDITED.

(c) THE ACCREDITATION SYSTEM SHALL OPERATE IN SUCH A MANNER THAT THE COSTS THEREOF SHALL BE PARTIALLY MET BY ACCREDITATION FEES PAID BY THE PARTICIPATING PRACTITIONERS. THE ACCREDITATION FEES SHALL COVER THE DIRECT AND INDIRECT COSTS OF THE ACCREDITATION SYSTEM. THE COMMISSIONER SHALL DETERMINE BY RULE THE ACCREDITATION FEE.

(d) THE ACCREDITATION SYSTEM SHALL BE ESTABLISHED SO AS TO PROVIDE PRACTITIONERS WITH AN UNDERSTANDING OF THE ADMINISTRATIVE, LEGAL, AND MEDICAL ASPECTS OF THE MEDICAL TREATMENT GUIDELINES AND THE REQUIREMENT OF MEDICAL NECESSITY. TO QUALIFY AS A PARTICIPATING PRACTITIONER, THE PRACTITIONER SHALL APPLY TO AND OBTAIN ACCREDITATION FROM THE PROGRAM MANAGER AND ATTEST TO HIS OR HER:

(I) UNDERSTANDING AND AGREEMENT TO PROVIDE MEDICALLY NECESSARY TREATMENT OR REFERRALS FOR BODILY INJURY ARISING OUT OF A MOTOR VEHICLE ACCIDENT IN ACCORDANCE WITH THE TREATMENT GUIDELINES ADOPTED PURSUANT TO THIS SECTION; AND

(II) ABILITY TO MEET OTHER REQUIREMENTS AS ESTABLISHED BY THE COMMISSIONER.

(e) THE APPLICATION FEES COLLECTED PURSUANT TO PARAGRAPH (c) OF THIS SUBSECTION (3) SHALL BE USED BY THE PROGRAM MANAGER FOR THE DIRECT AND INDIRECT COSTS OF ADMINISTERING THE PARTICIPATING PRACTITIONER PROGRAM.

**SECTION 7.** The introductory portion to 10-4-707 (1) and

10-4-707 (1) (a), (3), (4), (5), and (6), Colorado Revised Statutes, are amended, and the said 10-4-707 is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

**10-4-707. Benefits - how payable.** (1) ON AND AFTER JANUARY 1, 2004, the coverages described in section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 shall be applicable to:

(a) Accidental bodily injury sustained by the named insured when injured in ~~an~~ A MOTOR VEHICLE accident, ~~involving any motor vehicle,~~ regardless of whether the accident occurs in this state or in any other jurisdiction, except where the injury is the result of the use or operation of the named insured's own motor vehicle not actually covered under the terms of this part 7;

(3) ON AND AFTER JANUARY 1, 2004, except as provided in subsection (4) of this section, when a person injured is also an insured under a complying policy other than the complying policy insuring the vehicle out of the use of which the accident arose, ~~primary~~ coverage shall be afforded by the policy insuring said vehicle under section 10-4-706. ~~but in the event two or more insurers have obligations under complying policies to pay benefits to the same person, the limits of coverage available as benefits to such person shall be the limits of a single complying policy except to the extent that optional coverages purchased for additional premiums on a voluntary basis are applicable. In the event two or more insurers are liable to pay benefits on the same basis, any insurer paying benefits shall be entitled to an equitable pro rata contribution from such other insurer.~~

(4) ON AND AFTER JANUARY 1, 2004, when an accident involves

the operation of a motor vehicle by a person who is neither the owner of the motor vehicle involved in the accident nor an employee of the owner acting within the course and scope of employment at the time of the accident, and the operator of the motor vehicle is an insured under a complying policy other than the complying policy insuring the motor vehicle involved in the accident, ~~primary~~ PERSONAL INJURY PROTECTION coverage ~~as to all coverages provided in the policy under which the operator is an insured~~ FOR THE OPERATOR OR THE OPERATOR'S RESIDENT RELATIVE shall be afforded by the policy insuring the said operator. ~~except as provided in subsection (6) of this section, and any policy under which the owner is an insured shall afford excess coverage.~~ When an accident involves the operation of a motor vehicle regulated under the provisions of article 10 or 11 of title 40, C.R.S., the provisions of subsection (3) of this section shall apply.

(5) When a person injured is a person for whom benefits are required to be paid under the "Workers' Compensation Act of Colorado", the coverages described in section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 shall be reduced to the extent that benefits are actually available and covered under said act within the time period for payment of benefits under this part 7 prescribed by section 10-4-708.

(6) ON AND AFTER JANUARY 1, 2004, when an accident involves the operation of a motor vehicle designed to seat twelve or more passengers ~~which~~ AND THAT is owned by, and being operated on behalf of, a nonprofit religious, charitable, or educational organization entitled to tax exemption under section 501 (c) (3) of the federal "Internal Revenue Code of 1986", as amended, or an equivalent successor statutory

provision, with the exception of such vehicles owned or being operated on behalf of a public school district, the policy covering said vehicle shall be secondary ~~and excess~~ to any motor vehicle policy covering any person occupying said vehicle to the extent of such other policy coverages; except that the coverage of the operator or assistant operator of said vehicle, whether or not he OR SHE is being paid to operate the vehicle, shall be governed by the provisions of subsection (3) of this section. Nothing in this subsection (6) shall supersede the provisions of subsection (5) of this section.

(7) IF A PRACTITIONER WHOSE ACCREDITATION HAS BEEN TERMINATED PURSUANT TO THE CONTRACTUAL ARRANGEMENT WITH THE PROGRAM MANAGER PURSUANT TO SECTION 10-4-706.9 SUBMITS A CLAIM FOR PAYMENT FOR SERVICES NOT RENDERED IN EMERGENCY CIRCUMSTANCES AND RENDERED AFTER SUCH REVOCATION, THE PRACTITIONER SHALL BE IN VIOLATION OF SECTION 10-1-127 AND NEITHER THE INSURER NOR A SELF-INSURED PERSON SHALL BE UNDER ANY OBLIGATION TO PAY SUCH CLAIM.

(8) ON AND AFTER JANUARY 1, 2004, WHEN AN ACCIDENT INVOLVES A PEDESTRIAN AND THE PEDESTRIAN IS AN INSURED UNDER A COMPLYING POLICY OTHER THAN THE COMPLYING POLICY INSURING THE MOTOR VEHICLE INVOLVED IN THE ACCIDENT, THE COVERAGES DESCRIBED IN SECTION 10-4-706 OR 10-4-706.1 SHALL BE AFFORDED BY THE POLICY INSURING THE PEDESTRIAN.

(9) ON AND AFTER JANUARY 1, 2004, IN THE EVENT TWO OR MORE INSURERS HAVE OBLIGATIONS UNDER COMPLYING POLICIES TO PAY BENEFITS TO THE SAME PERSON, THE LIMITS OF COVERAGE AVAILABLE TO SUCH PERSON SHALL BE THE LIMITS OF A SINGLE COMPLYING POLICY

EXCEPT TO THE EXTENT THAT OPTIONAL COVERAGES PURCHASED FOR ADDITIONAL PREMIUMS ON A VOLUNTARY BASIS ARE APPLICABLE. IN THE EVENT TWO OR MORE INSURERS ARE LIABLE TO PAY BENEFITS ON THE SAME BASIS, ANY INSURER PAYING BENEFITS SHALL BE ENTITLED TO AN EQUITABLE PRO RATA CONTRIBUTION FROM SUCH OTHER INSURER.

**SECTION 8.** 10-4-708 (1), (1.7), (1.8), and (2), Colorado Revised Statutes, are amended, and the said 10-4-708 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

**10-4-708. Prompt payment of direct benefits.** (1) (a) ON AND AFTER JANUARY 1, 2004, payment of benefits under the coverages enumerated in section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 shall be made on a monthly basis. Benefits for any period are overdue if not paid within thirty days after the insurer receives reasonable proof of the fact and amount of expenses incurred during that period; except that an insurer may accumulate claims for periods not exceeding one month, and benefits are not overdue if paid within fifteen days after the period of accumulation. If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within thirty days after such proof is received by the insurer. Any part or all of the remainder of the claim that is later supported by reasonable proof is overdue if not paid within thirty days after such proof is received by the insurer. In the event ~~that the insurer fails to pay such benefits when due, the person entitled to such benefits may bring an action in contract to recover the same~~ OF A DISPUTE CONCERNING A CLAIM FOR BENEFITS, EITHER THE INJURED PERSON OR THE INSURER MAY BRING AN ACTION IN CONTRACT TO RESOLVE THE DISPUTE.

(b) FOR THE PURPOSES OF THIS SUBSECTION (1), "REASONABLE PROOF" MEANS EVIDENCE OF THE REASONABLE EXPENSES INCURRED FOR MEDICALLY NECESSARY CARE AND TREATMENT PURSUANT TO THE TREATMENT GUIDELINES FOR BODILY INJURY ARISING OUT OF A MOTOR VEHICLE ACCIDENT.

(1.7) (a) ON AND AFTER JANUARY 1, 2004, at least twenty days prior to the commencement of the proceeding, the party claiming the benefits shall set forth the amount claimed and in controversy in a separate document entitled "Notice to insurer of amount claimed", which shall include no more than those amounts the insured claims are denied or not timely paid by the insurer. The notice shall also specify the amount, if any, claimed for attorney fees. The notice shall be served on all parties no later than twenty days prior to the commencement of ~~the arbitration hearing or~~ A trial, and shall be served in the manner set forth in rules promulgated by the commissioner. ~~of insurance.~~ If such notice is not timely served, there shall be no award of attorney fees to the person claiming benefits unless the ~~arbitrator or~~ court determines that the failure was the result of excusable neglect, in which case the ~~arbitration or~~ trial shall be continued to a date at least twenty days after the notice is filed.

(b) Any payment by the insurer prior to trial ~~or arbitration which~~ THAT does not resolve all issues in dispute shall not be binding on the parties. Any payment by the insurer shall be agreed upon by all parties as resolving all issues in dispute or the ~~arbitration or~~ trial shall proceed on all unresolved issues.

(c) In determining the amount of attorney fees, if any, to be awarded to the insured, the ~~arbitrator or~~ court shall consider the following:

(I) The award of attorney fees to the insured shall be in direct proportion to the degree ~~by~~ TO which the insured was successful in the proceeding. The determination of the degree of the insured's success shall be based upon a comparison of the amount of benefits set forth in the notice of amount of benefits claimed and the amount of benefits recovered in the proceeding. The percentage resulting from this comparison shall be the degree ~~by~~ TO which the insured was successful.

(II) The ~~arbitrator or~~ court may modify the award of attorney fees as set forth in subparagraph (I) after considering the amount of and the timing of any written settlement offers made by any party as compared with the amount as set forth in the notice of amount of benefits claimed. A settlement offer shall not be shown to the ~~arbitrator or~~ court until after the finder of fact has determined the amount of benefits payable, if any.

(III) In no event shall the ~~arbitrator or~~ court enter an award of attorney fees ~~which~~ THAT is in excess of actual reasonable attorney fees.

(IV) The ~~arbitrator or~~ court may award reasonable attorney fees to the insurer if the ~~arbitrator or~~ court finds the action was prosecuted without substantial justification.

(1.8) The insurer shall pay interest to the insured on the benefits recovered at a rate of eighteen percent per annum, with interest commencing from the date the benefits recovered were due. In addition, in the event of willful and wanton failure of the insurer to pay such benefits when due, the insurer shall pay to the insured, in addition to any other amounts due to the insured under this subsection (1.8), an amount ~~which~~ THAT is three times the amount of unpaid benefits recovered in the proceeding. ~~By July 1 of each year, the commissioner by rule shall establish fee guidelines for the payment of arbitrators.~~

(2) ON AND AFTER JANUARY 1, 2004, benefits provided under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 may be paid by the insurer directly to any person supplying MEDICALLY necessary care, treatment, products, services, or accommodations to the person for whom benefits are required under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1.

(3) ON AND AFTER JANUARY 1, 2004, THE PROVISIONS OF THIS SECTION SHALL BE THE EXCLUSIVE REMEDY FOR A VIOLATION OF THIS SECTION.

**SECTION 9. Repeal.** 10-4-708 (1.5), (1.6), and (1.9), Colorado Revised Statutes, are repealed.

**SECTION 10.** 10-4-708.4 (3), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

**10-4-708.4. Assignment of payment - scope of benefits - provider reimbursement.** (3) (c) (I) ON AND AFTER JANUARY 1, 2004, AN INSURER MAY CONTRACT WITH A MEDICAL DATA PROCESSING FIRM OR OTHER PRICING ENTITY TO REVIEW THE REASONABLENESS OF PROVIDER CHARGES, OUTSIDE OF A MANAGED CARE CONTRACT PURSUANT TO SECTION 10-4-706.4, IN CONNECTION WITH THE PAYMENT OF PERSONAL INJURY PROTECTION BENEFITS PURSUANT TO SECTION 10-4-706 OR 10-4-706.1. AN INSURER USING A MEDICAL DATA PROCESSING FIRM OR OTHER PRICING ENTITY SHALL CONSIDER ADDITIONAL INFORMATION GIVEN TO THE INSURER BY A HEALTH CARE PROVIDER AND SHALL MAKE DECISIONS INDEPENDENT OF THE MEDICAL DATA PROCESSING FIRM OR OTHER PRICING ENTITY'S RECOMMENDATIONS WHEN APPROPRIATE.

(II) IT SHALL BE AN UNFAIR METHOD OF COMPETITION AND AN

UNFAIR OR DECEPTIVE TRADE PRACTICE IN THE BUSINESS OF INSURANCE, PURSUANT TO SECTION 10-3-1104 (1) (l), FOR AN INSURER TO REDUCE PAYMENT OF HEALTH CARE PROVIDER BILLS, OUTSIDE OF A MANAGED CARE CONTRACT PURSUANT TO SECTION 10-4-706.4, IN CONNECTION WITH THE PAYMENT OF PERSONAL INJURY PROTECTION BENEFITS BASED UPON THE RECOMMENDATIONS OF A MEDICAL DATA PROCESSING FIRM OR OTHER ENTITY, UNLESS THE INSURER REVIEWS AT LEAST ANNUALLY WHETHER THE DATA IN THE MEDICAL DATA PROCESSING FIRM OR OTHER PRICING ENTITY'S DATABASE IS CURRENT, ACCURATE, AND SUFFICIENT TO MAKE RECOMMENDATIONS REGARDING REASONABLE CHARGES FOR BILLS SUBMITTED AS PART OF PERSONAL INJURY PROTECTION CLAIMS.

**SECTION 11.** The introductory portion to 10-4-708.6 (1) (a) and 10-4-708.6 (1) (c), (2) (b), and (3), Colorado Revised Statutes, are amended to read:

**10-4-708.6. Obligations of persons providing services - penalties - availability and maintenance of records.** (1) (a) In addition to the standards set forth in section 10-4-706, it shall be the obligation of any health care practitioner or health care practitioner organization providing services for which compensation is provided under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 to assure, to the extent of such person's authority, that services or items ordered or provided by such person to beneficiaries and recipients under this part 7:

(c) Any person, provider, health care practitioner, health care practitioner organization, or other provider of benefits under section 10-4-706 ~~(1) (b) to (1) (e), (2), and (3),~~ OR 10-4-706.1 that violates the ~~standards~~ REQUIREMENTS of care in paragraph (a) or (b) of this subsection

(1) shall be subject to disciplinary action by the appropriate licensing authority.

(2) (b) Any person providing services for which compensation is provided under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 shall maintain the originals or copies of patient records justifying and relating to services provided under said section for a period of five years after the last date of examination or treatment of the patient.

(3) Any treatment or procedure recommended by a member of a managed care provider network pursuant to section 10-4-706 ~~(1) (b) or (1) (c) or the equivalent coverage in section 10-4-706 (2) or (3)~~ OR 10-4-706.1 shall be approved or denied within twenty business days after receipt of all information deemed necessary by the managed care organization to approve or deny the requested treatment or procedure.

**SECTION 12.** 10-4-709 (1), Colorado Revised Statutes, is amended to read:

**10-4-709. Coordination of benefits.** (1) To avoid duplication of benefits available through other insurance or contract rights, providers of other benefits under sections 10-16-104 (3) (b) (II) and (5), 10-16-108 (1) and (3), 10-16-214, 10-16-311, and parts 1 and 4 of article 16 of this title are hereby required to coordinate such benefits with coverages required under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 and all providers of other benefits are expressly authorized to coordinate such benefits with coverages required under this part 7. ~~The coordination of benefits provided in this subsection (1) shall apply to agreements entered into on or after April 1, 1974.~~

**SECTION 13.** 10-4-710 (1), (2), and (4) Colorado Revised Statutes, are amended to read:

**10-4-710. Required coverages are minimum.** (1) Nothing in this part 7 shall be construed to prohibit the issuance of policies providing coverages more extensive than the ~~minimum~~ coverages required under this part 7 nor to require the segregation of such ~~minimum~~ coverages from other coverages in the same policy. However, loss statistics as to bodily injury liability, property damage liability, and benefits under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 shall be kept separately for rating purposes and such statistics shall be filed with the commissioner each year.

(2) ~~(a) Every insurer shall offer the following enhanced benefits for inclusion in a complying policy, in addition to the basic coverages described in section 10-4-706, at the option of the named insured:~~

~~(I) Compensation of all expenses of the type described in section 10-4-706 (1) (b) without dollar or time limitation; or~~

~~(II) Compensation of all expenses of the type described in section 10-4-706 (1) (b) without dollar or time limitations and payment of benefits equivalent to eighty-five percent of loss of gross income per week from work the injured person would have performed had such injured person not been injured during the period commencing on the day after the date of the accident without dollar or time limitations.~~

~~(III) (Deleted by amendment, L. 92, p. 1779, § 2, effective April 10, 1992.)~~

~~(b) A complying policy may provide that all benefits set forth in section 10-4-706 (1) (b) to (1) (e) and in this section are subject to an~~

~~aggregate limit of two hundred thousand dollars payable on account of injury to or death of any one person as a result of any one accident arising out of the use or operation of a motor vehicle.~~

~~(4) The provisions of subsections (2) and (3) of this section as amended by House Bill 92-1175, enacted at the second regular session of the fifty-eighth general assembly, shall apply to policies issued on and after July 1, 1992.~~

**SECTION 14.** 10-4-712 (1) and (2) (b), Colorado Revised Statutes, are amended to read:

**10-4-712. Conditions and exclusions.** (1) The coverages described in section 10-4-706 may be subject to conditions and exclusions ~~which~~ THAT are not inconsistent with the requirements of this part 7. IN DETERMINING WHETHER CONDITIONS OR EXCLUSIONS ARE INCONSISTENT WITH THE REQUIREMENTS OF THIS PART 7, A COURT SHALL CONSIDER ALL FACTORS SET FORTH IN SECTION 10-4-702.

(2) The coverages described in section 10-4-706 may also be subject to exclusions where the injured person:

(b) Is operating a motor vehicle as a converter ~~without a good faith belief that he is legally entitled to operate or use such vehicle~~ AS DEFINED IN SECTION 10-4-703 (2.5).

**SECTION 15. Repeal.** 10-4-712 (3), Colorado Revised Statutes, is repealed.

**SECTION 16.** 10-4-713 (1), (2) (a), and (2) (b), Colorado Revised Statutes, are amended to read:

**10-4-713. No tort recovery for direct benefits.** (1) Neither any person eligible for direct benefits described in section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR

10-4-706.1 nor any insurer providing benefits described in section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 shall have any right to recover against an owner, user, or operator of a motor vehicle or against any person or organization legally responsible for the acts or omissions of such person in any action for damages for benefits required to be paid under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 regardless of any deductible option, waiting period, or percentage limitation; except that an insurer paying benefits under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 to or for any one person for whose injuries legal liability exists or may exist on the part of a third person who is not an insured under a policy of automobile liability insurance issued by an insurer licensed to write automobile liability insurance in this state shall have a direct cause of action against an alleged tort-feasor to only the extent of the alleged tort-feasor's insurance coverage in excess of reasonable compensation paid to the injured person for such person's injury or damage by the alleged tort-feasor's insurer when the injured person could recover in tort pursuant to section 10-4-714. Nothing in this section shall be construed to afford such provider of benefits under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 a cause of action or claim against a person to whom or for whom such benefits were paid, except in those cases in which such benefits were paid by reason of fraud or material misrepresentation of fact.

(2) (a) Notwithstanding the provisions of subsection (1) of this section, where a motor vehicle accident involves EITHER a private

passenger motor vehicle OR a public school vehicle designed to transport seven or more passengers and a nonprivate passenger motor vehicle, the insurer of the private passenger motor vehicle or the insurer of the vehicle designed to transport seven or more passengers shall have a direct cause of action for all benefits actually paid by such insurer under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 against the owner, user, or operator of the nonprivate passenger motor vehicle or against any person or organization legally responsible for the acts or omissions of such owner, user, or operator; except that, when the injured person could recover in tort pursuant to section 10-4-714, such direct cause of action shall be to only the extent of the alleged tort-feasor's insurance coverage in excess of reasonable compensation paid to the injured person for such person's injury or damage by the alleged tort-feasor's insurer.

(b) Notwithstanding the provisions of paragraph (a) of this subsection (2), where a motor vehicle accident involves EITHER a private passenger motor vehicle or a nonprivate passenger motor vehicle and a motor vehicle owned or operated by the regional transportation district, except maintenance or service vehicles owned or operated by the district, the insurer of the private passenger motor vehicle or the nonprivate passenger motor vehicle shall not have any cause of action or right of reimbursement for any benefits actually paid by such insurer under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 against the regional transportation district or against the user or operator of the regional transportation district motor vehicle.

**SECTION 17.** 10-4-714, Colorado Revised Statutes, is amended

to read:

**10-4-714. Limitation on tort actions.** (1) ON AND AFTER THE EFFECTIVE DATE OF HOUSE BILL 03-1225, no person for whom direct benefit coverage is required by operation of sections 10-4-705 to 10-4-707, or for whom direct benefits would have been payable but for exercise of a deductible option or but for a waiting period or percentage limitation, shall be allowed to recover against an owner, user, or operator of a motor vehicle, or against any person or organization legally responsible for the acts or omissions of such person, for damages for bodily injury caused by a motor vehicle accident, except in those cases in which there has been caused by a motor vehicle accident ONE OR MORE OF THE FOLLOWING:

(a) Death;

(b) (I) ~~Dismemberment~~ SERIOUS PERMANENT IMPAIRMENT OF BODILY FUNCTION.

(II) FOR THE PURPOSES OF THIS SECTION, "SERIOUS PERMANENT IMPAIRMENT OF BODILY FUNCTION" MEANS AN ACCIDENTAL AND OBJECTIVELY MANIFESTED SERIOUS AND PERMANENT IMPAIRMENT OF AN IMPORTANT BODY FUNCTION THAT SIGNIFICANTLY AFFECTS THE PERSON'S GENERAL ABILITY TO LEAD A NORMAL LIFE AS MANIFESTED BY THE PERSON'S SIGNIFICANT INABILITY TO PERFORM THE PRINCIPAL ECONOMIC OR NONECONOMIC ACTIVITIES THAT THE PERSON ENGAGED IN PRIOR TO THE ACCIDENT. A "SERIOUS PERMANENT IMPAIRMENT OF BODILY FUNCTION" MUST BE CLINICALLY ESTABLISHED ON THE BASIS OF OBJECTIVE DIAGNOSTIC TESTS AND MEASUREMENTS THAT ARE MEDICALLY RECOGNIZED.

(c) ~~Permanent disability;~~

(d) Permanent SERIOUS disfigurement.

(e) ~~Reasonable need for services of the type described in section 10-4-706 (1) (b) and (1) (c), (2) (a), or (3) (b) having a reasonable value in excess of two thousand five hundred dollars. "Reasonable value" as used in this paragraph (e) means the average cost of specific types of services described in section 10-4-706 (1) (b) and (1) (c), (2) (a), or (3) (b) in the state of Colorado as determined by the commissioner and published not less than once each year. Notwithstanding the provisions of this paragraph (e), no person shall be allowed to recover against an owner, user, or operator of a motor vehicle used in a ridesharing arrangement, as defined in section 10-4-707.5 (2), or against any person or organization legally responsible for the acts or omissions of such person for damages caused by a motor vehicle accident in which such vehicle was involved, if such vehicle was in use at the time of the accident in a ridesharing arrangement, as defined in section 10-4-707.5 (2), based on a reasonable need for services of the type described in section 10-4-706 (1) (b) and (1) (c), (2) (a), or (3) (b) unless such services have a reasonable value in excess of five thousand dollars.~~

(f) ~~Loss of earnings and loss of earning capacity extending beyond the fifty-two week period provided in section 10-4-706 (1) (d) or (3) (e) and not compensated by an applicable complying policy.~~

(2) ~~Nothing in this part 7 shall be construed to preclude recovery against an alleged tort-feasor of benefits provided or economic loss recoverable in excess of the minimum coverages required in section 10-4-706 (1) (b) to (1) (d), or, if applicable, to a person qualified under section 10-4-706 (3), in excess of alternative coverages.~~ THE ISSUES OF WHETHER AN INJURED PERSON HAS SUFFERED SERIOUS PERMANENT

IMPAIRMENT OF BODILY FUNCTION OR PERMANENT SERIOUS DISFIGUREMENT ARE QUESTIONS OF LAW FOR THE COURT IF THE COURT FINDS EITHER:

(a) THERE IS NO FACTUAL DISPUTE CONCERNING THE NATURE AND EXTENT OF THE PERSON'S INJURIES; OR

(b) THERE IS A FACTUAL DISPUTE CONCERNING THE NATURE AND EXTENT OF THE PERSON'S INJURIES, BUT THE DISPUTE IS NOT MATERIAL TO THE DETERMINATION AS TO WHETHER THE PERSON HAS SUFFERED A SERIOUS PERMANENT IMPAIRMENT OF BODILY FUNCTION OR PERMANENT SERIOUS DISFIGUREMENT. HOWEVER, FOR A CLOSED-HEAD INJURY, A QUESTION OF FACT FOR THE JURY IS CREATED IF A LICENSED ALLOPATHIC OR OSTEOPATHIC PHYSICIAN WHO REGULARLY DIAGNOSES OR TREATS CLOSED-HEAD INJURIES TESTIFIES UNDER OATH THAT THERE IS A SERIOUS NEUROLOGICAL INJURY.

(3) NOTHING IN THIS PART 7 SHALL BE CONSTRUED TO PRECLUDE RECOVERY AGAINST AN ALLEGED TORT-FEASOR OF BENEFITS PROVIDED OR ECONOMIC LOSS RECOVERABLE IN EXCESS OF THE MINIMUM COVERAGES REQUIRED IN SECTION 10-4-706 OR 10-4-706.1.

**SECTION 18.** Part 7 of article 4 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

**10-4-714.5. Applicability of other law.** ON AND AFTER THE EFFECTIVE DATE OF HOUSE BILL 03-1225, THE PROVISIONS OF TITLE 6, C.R.S., SHALL NOT APPLY TO ACTIONS FILED AGAINST AN INSURER OR ANY OF ITS PRODUCERS, AS LICENSED PURSUANT TO SECTION 10-2-401, CONDUCTING BUSINESS PURSUANT TO THIS PART 7.

**SECTION 19.** The introductory portion to 10-4-715 (1),

Colorado Revised Statutes, is amended, and the said 10-4-715 (1) is further amended BY THE ADDITION OF A NEW PARAGRAPH, to read:

**10-4-715. No limitation on tort action against noncomplying tort-feasors.** (1) ON AND AFTER THE EFFECTIVE DATE OF HOUSE BILL 03-1225, nothing in this part 7 shall be construed to limit the right to maintain an action in tort by either a provider of direct benefits under section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 or by a person who has been injured or damaged as a result of an automobile accident against an alleged tort-feasor where such alleged tort-feasor was: ~~either:~~

(e) A PERSON WHOSE LIABILITY DOES NOT ARISE OUT OF THE USE OF A MOTOR VEHICLE BY THAT PERSON OR BY SOMEONE ELSE FOR WHOSE NEGLIGENCE THE PERSON IS VICARIOUSLY OR DERIVATIVELY LIABLE.

**SECTION 20.** 10-4-716 (2), Colorado Revised Statutes, is amended to read:

**10-4-716. Self-insurers.** (2) The commissioner may, in his or her discretion, upon the application of ~~such person~~ A PERSON IN WHOSE NAME MORE THAN TWENTY-FIVE MOTOR VEHICLES ARE REGISTERED, issue a certificate of self-insurance when the commissioner is satisfied that such person is able and will continue to be able to pay direct benefits as required under section 10-4-706 ~~(1) (b) to (1) (e)~~ OR 10-4-706.1 and to pay any and all judgments that may be obtained against such person. Upon not less than five days' notice and a hearing pursuant to such notice, the commissioner may, upon reasonable grounds, cancel a certificate of self-insurance. Failure to pay any benefits under section 10-4-706 ~~(1) (b) to (1) (e)~~ OR 10-4-706.1 or failure to pay any judgment within thirty days

after such judgment shall have become final shall constitute a reasonable ground for the cancellation of a certificate of self-insurance.

**SECTION 21.** The introductory portion to 10-4-717 (1) and 10-4-717 (1) (a) and (3), Colorado Revised Statutes, are amended to read:

**10-4-717. Intercompany arbitration.** (1) Every insurer licensed to write motor vehicle insurance in this state shall be deemed to have agreed: ~~as a condition to maintaining such license after January 1, 1974:~~

(a) That, where its insured is or would be held legally liable under the provisions of section 10-4-713 (2) for the benefits paid by another insurer described in section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1, it will reimburse such other insurer to the extent of such benefits but not in excess of the amount of damages so recoverable for the type of loss covered by such benefits and only to the extent of the alleged tort-feasor's insurance coverage in excess of reasonable compensation paid to the injured person for such person's injury or damage by the alleged tort-feasor's insurer; and

(3) Notwithstanding any statute of limitations to the contrary, any demand for initial arbitration proceedings shall be brought within one year ~~of~~ AFTER the first payment of any of the benefits described in section 10-4-706 ~~(1) (b) to (1) (e) or alternatively, as applicable, section 10-4-706 (2) or (3)~~ OR 10-4-706.1 by the insurer claiming for reimbursement. Arbitration proceedings need not await final payment of benefits, and the award, if any, shall include provisions for reimbursement of subsequent benefits. Proceedings may be reopened to challenge the propriety of payments subsequently made, but no question of fact decided by a prior award shall be reconsidered in any such subsequent hearing.

**SECTION 22.** 10-4-720 (1), Colorado Revised Statutes, is

amended to read:

**10-4-720. Cancellation - renewal - reclassification.** (1) Except in accordance with the provisions of this part 7, no insurer shall:

(a) Cancel or fail to renew a policy of insurance ~~which~~ THAT complies with this part 7, issued in this state, as to THE NAMED INSURED, RESIDENT SPOUSE, OR any resident of the household of the named insured, for any reason other than nonpayment of premium, ~~or~~ FRAUD, CONCEALMENT, OR MATERIAL MISREPRESENTATION BY THE NAMED INSURED, RESIDENT SPOUSE, OR A RESIDENT RELATIVE, IN CONNECTION WITH THE APPLICATION FOR INSURANCE OR ANY CLAIM FOR BENEFITS;

(b) Increase a premium for any coverage on any such policy, unless the increase is part of a general increase in premiums filed with the commissioner and does not result from a reclassification of the insured; or

(c) Reduce the coverage under any such policy, unless the reduction is part of a general reduction in coverage filed with the commissioner or to satisfy the requirements of other sections of this part 7.

**SECTION 23.** 10-4-721 (1), Colorado Revised Statutes, is amended to read:

**10-4-721. Exclusion of named driver.** (1) ON AND AFTER THE EFFECTIVE DATE OF HOUSE BILL 03-1225, in any case where an insurer is authorized under this part 7 to cancel or refuse to renew or increase the premiums on an automobile liability insurance policy under which more than one person is insured because of the claim experience or driving record of ~~one or more but less than all of the persons insured under the policy~~ A PERSON OTHER THAN THE NAMED INSURED, the insurer shall in

lieu of cancellation, nonrenewal, or premium increase offer to continue or renew the insurance but to exclude from coverage, by name, the person whose claim experience or driving record would have justified the cancellation or nonrenewal. The premiums charged on any such policy excluding a named driver shall not reflect the claims, experience, or driving record of the excluded named driver.

**SECTION 24.** 10-4-726, Colorado Revised Statutes, is amended to read:

**10-4-726. Repeal of part.** (1) This part 7 is repealed, effective July 1, ~~2003~~ 2006.

(2) ON OR BEFORE FEBRUARY 1, 2006, THE DEPARTMENT OF REGULATORY AGENCIES SHALL CONDUCT A REVIEW AND EVALUATION OF THE IMPACT ON CONSUMERS AND THE INSURANCE INDUSTRY OF THE REFORMS ENACTED IN HOUSE BILL 03-1225. THE DEPARTMENT OF REGULATORY AGENCIES SHALL SUBMIT A REPORT OF SUCH EVALUATION TO THE BUSINESS AFFAIRS AND LABOR COMMITTEES OF THE HOUSE OF REPRESENTATIVE AND THE SENATE.

**SECTION 25.** 10-4-609, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

**10-4-609. Insurance protection against uninsured motorists - applicability.** (6) (a) ON AND AFTER THE EFFECTIVE DATE OF HOUSE BILL 03-1225, AN INSURER SHALL BE DEEMED TO HAVE COMPLIED WITH THE REQUIREMENTS OF SUBSECTION (1) OF THIS SECTION AND THE EXCLUSION OF THE INSURED FROM UNINSURED MOTORIST COVERAGE SHALL BE DEEMED VALID IF THE NAMED INSURED HAS REJECTED THE UNINSURED MOTORIST COVERAGE IN WRITING. SUCH EXCLUSION SHALL CONTINUE UNTIL SUCH TIME AS THE INSURED REQUESTS THAT THE INSURER

PROVIDE UNINSURED MOTORIST COVERAGE. IF PURCHASED ON A SPECIFIC MOTOR VEHICLE, UNINSURED AND UNDERINSURED MOTORIST COVERAGE SHALL APPLY ONLY TO SUCH MOTOR VEHICLE.

(b) OWNED-BUT-UNINSURED EXCLUSIONS ARE PERMISSIBLE IN THIS STATE. OWNED-BUT-UNINSURED EXCLUSIONS MAY BE INCLUDED IN MOTOR VEHICLE INSURANCE POLICIES AND UNINSURED OR UNDERINSURED COVERAGE MUST BE PURCHASED OR REJECTED ON A VEHICLE-BY-VEHICLE BASIS. UNINSURED AND UNDERINSURED COVERAGE APPLIES ONLY TO VEHICLES FOR WHICH THE COVERAGE WAS SELECTED AND FOR WHICH A PREMIUM WAS PAID, AND DOES NOT FOLLOW THE PERSON.

**SECTION 26.** 10-3-207 (1) (d), Colorado Revised Statutes, is amended to read:

**10-3-207. Fees paid by insurance companies.** (1) There shall be paid to the division of insurance by every entity regulated by the division of insurance in this state the following:

(d) (I) UNTIL JANUARY 1, ____, in addition to any fee collected under paragraph (a) or (b) of this subsection (1), every insurance entity authorized to write private passenger automobile insurance coverage shall pay an annual fee not to exceed four hundred dollars to fund the costs of establishing and administering the PIP examination program established in section 10-4-706. Such fee shall be set by rule promulgated by the commissioner. Fees collected under this ~~paragraph (d)~~ SUBPARAGRAPH (I) shall be transmitted to the state treasurer, who shall credit the same to the division of insurance cash fund created in section 10-1-103 (3).

(II) (A) ON AND AFTER JANUARY 1, 2004, IN ADDITION TO ANY FEE COLLECTED UNDER PARAGRAPH (a) OR (b) OF THIS SUBSECTION (1) OR SUBPARAGRAPH (I) OF THIS PARAGRAPH (d), EVERY INSURANCE ENTITY

AUTHORIZED TO WRITE PRIVATE PASSENGER AUTOMOBILE INSURANCE COVERAGE IN THIS STATE SHALL PAY AN ANNUAL FEE NOT TO EXCEED _____ HUNDRED DOLLARS TO FUND THE FUNCTIONS AND ACTIVITIES OF THE PROGRAM MANAGER, INCLUDING, BUT NOT LIMITED TO ANY EXPENSES INCURRED BY THE DIVISION OF INSURANCE FOR RULE-MAKING OR IMPLEMENTATION OF THE PROVISIONS CONCERNING THE PROGRAM MANAGER. SUCH FEE SHALL BE COLLECTED AND PAID DIRECTLY TO THE PROGRAM MANAGER CONTRACTED WITH PURSUANT TO SECTION 10-4-706.9.

(B) ANY MONEYS REMAINING IN THE PIP EXAMINATION PROGRAM COLLECTED PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH (d) ON JULY 1, 2009, SHALL BE TRANSMITTED TO THE PROGRAM MANAGER CONTRACTED WITH PURSUANT TO SECTION 10-4-706.9.

**SECTION 27. No appropriation.** The general assembly has determined that the review to be performed by the department of regulatory agencies can be implemented within existing appropriations, and therefore no separate appropriation of state moneys is necessary to carry out the purposes of this act.

**SECTION 28. Effective date - applicability.** (1) (a) Section 16 shall take effect on passage an apply to tort actions filed on or after passage; and

(b) Sections 6, 18, 19, 23, 24, 27, 28, and 29 shall take effect upon passage.

(2) The remaining sections of this act shall take effect January 1, 2004, and shall apply to insurance policies issued or renewed and motor vehicle accidents occurring on or after said date.

**SECTION 29. 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.