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0297 Committees on: Medical Care Cost Containment, Sentencing and Criminal Justice

Colorado Legislative Council

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Report to the Colorado General Assembly:

RECOMMENDATIONS FOR 1986 COMMITTEES ON:

Medical Care Cost Containment
Sentencing and Criminal Justice

COLORADO LEGISLATIVE COUNCIL

RESEARCH PUBLICATION NO. 297
December, 1985

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OF THE

COLORADO GENERAL ASSEMBLY

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COLORADO LEGISLATIVE COUNCIL

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Sentencing and Criminal Justice

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COLORADO GENERAL ASSEMBLY

LEGISLATIVE COUNCIL

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To Members of the Fifty-fifth Colorado General Assembly:

Submitted herewith are the final reports of the Committee on Medical Care Cost Containment and the Committee on Sentencing and Criminal Justice. These two committees were appointed by the Legislative Council pursuant to House Joint Resolution No. 1025, 1985 session.

At its meeting of October 15, the Legislative Council reviewed the reports and recommendations of the two committees. A motion to forward the report and recommendations of the Committee on Medical Care Cost Containment to the Fifty-fifth General Assembly was approved. Two bills recommended by the Committee on Sentencing and Criminal Justice were not approved by the Legislative Council. One bill pertained to the jurisdiction of the Court of Appeals and was rejected because the bill appears to be beyond the charge to the committee. The other bill provided authorization for the contacting of correctional facilities and services to private contractors. The bill was rejected because of concern over the granting of immunity from liability to private contractors. These two bills are not included in this report but are on file in the Legislative Council office or the Legislative Drafting office for review by any interested person. Minus these two bills, a motion to forward the report and recommendations of the committee to the Fifty-fifth General Assembly was approved.

Respectfully submitted,

/s/ Representative Carl B "Bev" Bledsoe
Chairman
Colorado Legislative Council

CBB/eg

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LEGISLATIVE COUNCIL

COMMITTEE ON MEDICAL CARE COST CONTAINMENT

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SUMMARY OF RECOMMENDATIONS

The Committee on Medical Care Cost Containment was directed by House Joint Resolution 1025 to continue to identify the problems of increasing medical costs as they affect the private and public sectors. Specifically, the committee was directed to evaluate mechanisms to pay for the health care costs of medically indigent, uninsured, and underinsured persons in a manner that is productive and efficient from the cost and health outcomes standpoint, to evaluate alternative methods of funding the treatment of catastrophic illness, to examine various strategies for the delivery and financing of long term health care services, and to evaluate the availability of comprehensive health care coverage for self-employed persons and small business employees, including an examination of methods to provide access to affordable health care to these individuals.

The committee established the following three major goals to guide its study:

1) evaluation of the current state Medically Indigent program;

2) examination of alternative methods of financing long term health care; and

3) examination of the feasibility of establishing a health insurance risk pool for currently uninsurable persons.

In this effort, the committee held twelve meetings, received testimony from numerous witnesses, and discussed issues with representatives of national organizations involved in various aspects of the health care industry. The committee worked throughout the interim on a bill to revise the Medically Indigent program administered by the University of Colorado Health Sciences Center.

Although work on the Medically Indigent program bill continued throughout the interim, the last four meetings were primarily devoted to an examination of other proposed legislation. The committee recommends a total of thirteen bills and one constitutional amendment. These bills and the constitutional amendment are summarized in the background report. Briefly, the following bills and constitutional amendment are recommended:

Bill 17 -- revises the Medically Indigent program (includes: addition of a definition of a medically indigent person, authorization to the administrator to solicit competitive bids from providers, separation of the education and research appropriation from the indigent care appropriation, etc.);

Bill 18 -- makes an appropriation to the University of Colorado Health Sciences Center to pay for the medical needs of children under three and pregnant women;

Bill 19 -- requires motorcycle operators and passengers to wear protective helmets;

Bill 20 -- provides for continued health benefits plan coverage upon termination of employment;

Bill 21 -- creates a state health insurance risk pool;

Bill 22 -- expands the taxation of health financing plans;

Bill 23 -- allows deductions from Colorado adjusted gross income for contribution to an individual medical account;

Bill 24 -- establishes specific procedures for the provision of a statement of informed consent to a proposed medical procedure;

Bill 25 -- creates a pretrial panel to determine the merit of medical malpractice claims;

Bill 26 -- repeals the Colorado Certificate of Public Necessity Act;

Bill 27 -- provides for the employment of physicians by hospitals, hospital-owned corporations, and health maintenance organizations;

Bill 28 -- repeals the requirement for rubella immunity and Rh type testing for female marriage license applicants;

Bill 29 -- amends the Colorado Constitution to eliminate the Old Age Pension-B program on and after January 1, 1987;

Bill 30 -- authorizes the Department of Social Services to negotiate contracts with vendors to provide Medicaid services on a prepaid capitated basis; and

Bill 31 -- repeals the estate planning exception to the general prohibition on the assignment or transfer of property without fair and valuable consideration in determining public assistance eligibility.

INTRODUCTION

The 1985 interim Committee on Medical Care Cost Containment was established to continue the work of a 1984 interim committee which focused on the same subject. Because of the enormity of the committee's task in 1984 to propose meaningful state actions designed to contain the growth of health care spending, the Fifty-Fifth General Assembly recommended that the 1984 study be continued through the 1985 interim. In addition, continuation of the health care cost containment study allowed a legislative body to monitor both developments in the health care system and cooperation between the various system components -- health care providers, labor, business, industry, insurance carriers, and government.

The 1984 interim committee recommended eight bills and one constitutional amendment; five of these bills were enacted during the 1985 legislative session. The following bills were not passed during 1985:

-- Senate Bill 17, Concerning the Program for the Provision of Health Care Services for the Medically Indigent;

-- House Bill 1026, Concerning Limitations on the Practice of Medicine;

-- House Bill 1083, Concerning Limitation of Actions Against Physicians; and

-- House Concurrent Resolution 1001, Submitting to the Registered Electors of the State of Colorado an Amendment to Section 3 of Article XXIV of the State of Colorado, Changing the Minimum Age of Eligibility for Public Assistance in the Form of Old Age Pensions to Age Sixty-Five.

Although the 1985 interim committee continued to study the overall problem of increasing health care costs, the membership decided to particularly focus on three aspects of the health care industry. Specifically, the committee undertook an evaluation of the current state Medically Indigent program, including an examination of methods to decrease the medically indigent population, an examination of the feasibility of establishing a health insurance risk pool for currently uninsurable persons, and an examination of alternative methods of financing long term care. This report briefly describes the committee's findings in these three areas, as well as summarizing each of the committee's recommendations.

MEDICAL INDIGENCY

Introduction

One of the problems in the health care industry is that millions of Americans lack access to health care because they have no insurance coverage. The United States Department of Health and Human Services reported, in 1984, that 50.7 million Americans were either uninsured or underinsured. In January, 1983, the Colorado Task Force on the Medically Indigent was formed to investigate the problems associated with financing health care for those who cannot afford it. Recognizing that medical indigency can result not only from poverty, the Task Force defined as medically indigent those persons who cannot afford needed medical care because of poverty, lack of insurance, or inadequate insurance coverage. Research by the Task Force indicates that approximately twenty percent of the state's population (629,000 persons) fell under 150 percent of the poverty line in 1983. Although most of these persons had private insurance or were covered by public assistance programs, over one-third (238,000 persons) had no insurance at that time.

The Task Force focused on three separate groups of potentially medically indigent persons: the uninsured poor; the poor and nonpoor with inadequate insurance; and the nonpoor with high cost illness. The Task Force found that while most of the poor have some form of health insurance protection, many may have inadequate policies. Insurance coverage for the majority of middle and upper income residents appears to be fairly broad and adequate enough to protect against medical indigency. A survey done by the Task Force staff of a group of commercial insurance carriers in Colorado indicates that over 80 percent of the population covered by these insurers would be protected from medical indigency if they could afford to pay up to $3,000 in medical costs per year. However, further research done by the Task Force did show that high cost illnesses not fully covered by insurance may result in medical indigency for all income levels of Coloradans. In 1981, approximately 31,000 Colorado families had uninsured medical bills which exceeded 25 percent of their income.

Although the state of Colorado does operate a state-only funded medically indigent program, the interim committee was interested in exploring legislative means to decrease the population potentially eligible for the program. Much of the public policy discussion of medically indigent care focuses on the word "indigent"; there are many potentially medically indigent persons in Colorado who could benefit from legislative aid to avoid becoming indigent. Thus, two policies may be needed: one for the poor with little or no insurance coverage; and a second for those who are not poor but who also have little or no insurance coverage for various reasons. The committee recommends four bills in this area: Bill 17 revises and finetunes the current Medically Indigent program; Bill 18 appropriates additional funds to the Medically Indigent program for prenatal care; Bill 19 reinstates

the mandatory motorcycle helmet law; and Bill 20 requires all commercial insurers, hospital or medical service corporations, and health maintenance organization to provide for continued health insurance coverage for one year upon employment termination.

State Funded Medically Indigent Program

Medically Indigent Program, 1974-1983

In 1974, a legislative subcommittee on Core City Problems was instrumental in obtaining an appropriation from the General Assembly to provide funds for the city and county of Denver for partial support of Denver General Hospital. In part, the subcommittee made the recommendation because the indigent caseload at private hospitals in the Denver area was only a fraction of that of Denver General Hospital. It was argued that if Denver General were to close, the caseload would simply shift to Colorado General Hospital. 1/ Subsequently, the General Assembly appropriated to the Department of Social Services a total of $11,950,000 for indigent care. 2/ Although the bulk of funds were allocated to Denver General Hospital, monies were also provided to other participating public hospitals.

At the inception of the Medically Indigent program, the Department of Social Services was responsible for program administration. During the 1982 session, program administration was shifted from the Department of Social Services to the Regents of the University of Colorado. 3/ There were three reasons given for the change in administration:

-- the University of Colorado Health Sciences Center was statutorily authorized to provide care for the medically indigent, while such authorization did not exist for the Department of Social Services;

-- the transfer of this program, along with the transfer of the Community Maternity Program from the Department of Health, provided for the consolidated administration of medically indigent services in a unit which was an actual provider of medical service; and

-- data gathering capabilities were to be improved by placing the program in the Health Sciences Center.

1/ "Report to the Joint Budget Committee on Core City Problems", Subcommittee on Core City Problems, February 19, 1974, page 5.

2/ Chapter 22, Session Laws of Colorado, 1974, page 157.

3/ Chapter 1, footnotes 40, 41, and 42, Session Laws of Colorado, 1982, pages 69 and 70.

The 1982 Long Bill designated 95 percent of the Medically Indigent program appropriation to Denver General Hospital. In a footnote to the Long Bill, the General Assembly indicated that fiscal year 1982 would be the final year of state general fund support for the medically indigent as a separate line item unless statutory authority for the program was established. 4/

Statutory Medically Indigent Program

During the 1983 session, the General Assembly passed House Bill 1129 which created a statutorily authorized Medically Indigent program. The bill added article 15 -- the Reform Act for the Provision of Health Care for the Medically Indigent -- to title 26 of the Colorado Revised Statutes. Program administration remained with the University of Colorado Health Sciences Center. The program established by this article is not an entitlement program; it was set up to provide payment to providers for the provision of medical services to eligible indigent persons (26-15-104, C.R.S.).

Pursuant to section 26-15-105, C.R.S., the Health Sciences Center is to prepare an annual report on the Medically Indigent program. The report is to include recommendations regarding the following program components, among others: eligibility, ability-to-pay schedules, copayments, third-party collections, fraud prevention, priorities for provision of medical services, a central registry, and sources of funding and projected costs.

Section 26-15-106, C.R.S. establishes the perimeters of the program and the responsibilities of the Health Sciences Center as program administrator. The following requirements are provided for in section 26-15-106:

-- the Health Sciences Center is responsible for the execution of contracts with providers for medically indigent services;

-- the Health Sciences Center is responsible for promulgating rules for the program and submission of the annual report concerning the program;

-- contracts are negotiated between the Health Sciences Center and providers and are to include provision of tertiary and specialized care with certain providers;

-- the provider is responsible for determining eligibility but every contract is to require the person seeking assistance to provide proof of indigency;

4/ Chapter 1, footnote 42a, Session Laws of Colorado, 1982, page 70.

-- contracts are to reflect medical services rendered to the indigent in different regions of the state on a geographic basis (this provision became mandatory upon passage of Senate Bill 21 during the 1985 legislative session);

-- Denver Health and Hospitals was designated as the primary provider of medical services for the medically indigent in the city and county of Denver, while the Health Sciences Center was made the primary provider for the Denver metropolitan area;

-- contracts are to specify the aggregate level of funding available for medically indigent care;

-- emergency medical services provided to the indigent are given first priority in reimbursement;

-- 40 percent of provider funds are to be spent for inpatient care, 59 percent for outpatient care, and one percent for transportation; and

-- the Health Sciences Center was to establish patient per diem standards for comparable care to be effective July 1, 1984.

The Health Sciences Center subcontracted administration of the Community Maternity Program to the Department of Health. Pursuant to section 26-15-109, C.R.S., providers are awarded contracts for maternity services and reimbursed for low-risk deliveries at a single negotiated fee. For those women experiencing complications prior to or during delivery or who have babies who require extended newborn care, reimbursement is at a variable negotiated rate.

Although House Bill 1129 established a statutorily authorized Medically Indigent program, certain aspects of the program have continued to be governed by Long Bill footnote. Pursuant to footnote 48 of Senate Bill 401 (1983 Long Bill), providers were required to contribute three percent of their operating expenses to charity care prior to participating in the program during the 1983-84 fiscal year. Footnote 43 of House Bill 1425 (1984 Long Bill) explained the separate line item appropriation for specialty health care for the medically indigent. It stated that the appropriation would reimburse those providers which primarily provide specialty care such as Children's Hospital and the American Cancer Research Center. University Hospital and Denver Health and Hospitals were not eligible for this appropriation, and one-half of the funds were to be allocated to the care of out-state residents. The instructions for the use of the specialty health care appropriation are repeated in footnote 49 of Senate Bill 250 (1985 Long Bill).

Since the Health Sciences Center became the program administrator in 1982 occasions of service and state appropriations have increased. In fiscal year 1982-83, the total occasions of service provided by the program were 301,719 and the appropriation from the state was $18,782,985. In fiscal year 1983-84, the total occasions of service

provided were 328,740 and the program appropriation was $19,272,015. In fiscal year 1984-85, the total occasions of service provided were 352,756 and the program appropriation was $33,836,185. The 1984-85 figure includes the amount appropriated to the Health Sciences Center for indigent care at University Hospital while fiscal years 1982-83 and 1983-84 do not include those amounts.

Committee Activities

Testimony by Mr. Robert Dickler, director, University Hospital, indicated that he, as program administrator, has some concern with the current status of the program. These concerns included the following general issues.

-- Whether the program is intended to be or should be changed to an insurance-type program providing fee-for-service, capitation, or other types of coverage. Although the current program is not funded at a level to enable insurance-type coverage, uncompensated care remains a problem for providers treating indigent patients.

-- Whether the definitions of a program provider and an eligible participant should be expanded or clarified. Issues concerning provider eligibility include the possible expansion of eligible providers, the exclusion of some providers due to location and cost, and the potential geographic distribution of providers. Issues concerning participant eligibility include the addition of a statutory definition of a medically indigent person, and eligibility determination based on income levels, insurance availability, citizenship, etc.

-- Whether a total change should be made in the nature of the state's medically indigent programs or whether the programs should be incrementally changed to expand or modify coverage.

In addition, committee members expressed concern with the current cost-based reimbursement system used in the program. Committee members indicated that it was important to find some method to identify more efficient providers and reward them with a larger market share of indigent patients. Essentially, the problem facing the committee was to determine what sort of Medically Indigent program is best for Colorado; is it possible for the state to deliver high-quality, cost-effective care to a population unable to afford to pay for its needed medical services?

Testimony throughout the interim, numerous discussions among committee members, and examination of the bill recommended by the 1984 interim committee (Senate Bill 17) led the committee to the conclusion that the current structure of the program is providing the best use of the state's dollars. The program is funded only by the state, it is not an entitlement program, and its annual appropriation is determined by the General Assembly. Based on this conclusion, Bill

17, recommended by the 1985 interim committee, retains the basic program structure while revising and finetuning specific aspects of the program.

As part of the effort to move away from cost-based reimbursement, the program administrator, Mr. Dickler, was asked to report to the committee regarding the feasibility of various program reimbursement mechanisms, the length of time and the cost of implementing new payment systems, and the administrator's recommended approach for determining Medically Indigent program payment. After considerable study, Mr. Dickler recommended the use of the Medicare Diagnostic Related Groups (DRGs) classification system for reimbursement of medically indigent inpatient services.

This proposal recommends the use of the DRG system as the most widely utilized and accepted system classifying all inpatient activity into categories. In addition, use of the Medicare pricing schedule is recommended because all general hospitals are familiar with it, and because development of a specific pricing schedule for Colorado would require extensive time, effort, and resources. Each participating hospital would be reimbursed a specified percentage of the DRG for a procedure. The proposal recommended by the administrator urges that reimbursement for outpatient care, professional fees, and ambulatory care continue as they are currently handled by the program.

The financial impact of the proposal is dependent on the level of appropriations, the level and source of educational funding, the number of participating providers, the volume of care provided, and greater knowledge of DRG reimbursement rates. Mr. Dickler noted that it should not be assumed that funding levels for providers other than the Health Sciences Center and Denver Health and Hospitals would increase. In fact, given current appropriation levels and reimbursement rates, a strong probability exists that reimbursement levels and the aggregate appropriation for outstate providers would decrease with the use of the Medicare DRG system.

The committee decided to retain the current Medically Indigent program reimbursement mechanism given the fact that outstate hospitals might not be aided by conversion to the DRG system at this time. Bill 17 does revise the current system to provide, however, that the Health Sciences Center reimburse itself, as a provider, at a rate not exceeding that given to other providers. Each contract with a provider is to provide for the reimbursement of a percentage of the average cost of each medical service provided. This percentage will be periodically adjusted based on available appropriations.

Committee Recommendations

Concerning the Program for the Provision of Health Care Services for the Medically Indigent -- Bill 17. Bill 17 revises the Colorado Medically Indigent Health Care Act which establishes a program administered by the University of Colorado Health Sciences Center. It

declares that the purpose of the program is to aid local governments and local hospitals in carrying out their traditional responsibility to provide medical services to the indigent population. A definition of a medically indigent person is added to the statutes in Bill 17 with the caveat that meeting the definition does not necessarily entitle a person to program services. The definition of provider is also expanded to include free-standing emergency and ambulatory surgical facilities and to delete associated physicians.

A significant change made by Bill 17 explicitly requires the program administrator to promulgate rules to implement the program in accordance with the Administrative Procedures Act. The administrator may refuse to contract with, to renew a contract with, or revoke a contract with a provider failing to comply with the rules. These rules are to require the provider to use and enforce the ability-to-pay scale and copayment schedule approved by the program administrator.

Bill 17 revises the current program reimbursement system to provide that the Health Sciences Center reimburse itself, as a provider, at a rate not exceeding that given to other providers. Each contract with a provider is to provide for the reimbursement of a percentage of the average cost of each medical service provided. This percentage will be periodically adjusted based on available appropriations. In order for this reimbursement system to be equitable, the bill requires the annual general appropriation act to provide separate line items for: 1) education and research programs funded by the state at Denver Health and Hospitals and the Health Sciences Center; and 2) the reimbursement of all providers under the program. In addition, the bill requires the administrator to develop a range of reimbursement options for legislative consideration.

The designation of Denver Health and Hospitals as the primary provider of indigent care in the city and county of Denver and the designation of the Health Sciences Center as the primary provider of indigent care in the Denver metro area is removed by Bill 17. In addition, the program administrator is authorized to solicit competitive bids from providers seeking program participation. Additional hospitals may be contracted with to provide complex care for the program.

Eligibility in the program is only valid for one year following a determination of eligibility. Bill 17 authorizes the program administrator to obtain records pertinent to the determination of eligibility from the Department of Labor and Employment. A medically indigent person who signs an application waives any right to file a civil action for damages arising out of good faith acts or omissions of participating providers.

The bill states that the Health Sciences Center will not reimburse providers for inpatient services which could have been performed less expensively in an outpatient setting. Outpatient emergency care and inpatient hospital care when immediately necessary

are services eligible for program reimbursement. Those services specifically not reimbursable, except for life-threatening emergencies, include renal dialysis, mental health or psychiatric treatment, alcoholism or controlled substance abuse treatment, cosmetic surgery, dental care, patient transportation, and prescription drugs.

Bill 17 also abolishes the Joint Review Committee for the Medically Indigent and the Technical Advisory Committee on the Medically Indigent. The bill specifies that the Medically Indigent program is the payor of last resort and is not to duplicate county or regional programs funded by the Department of Health. The program's sunset date is also repealed, thus, the program becomes permanent.

Prenatal Care

The cost of providing health care to premature and low birth weight infants is significant. Premature and low birth weight babies are generally defined as children born before 37 weeks of gestation and usually weighing less than five and one-half pounds. Overall, the delivery and care of newborns are the most frequent reasons for admission to Colorado hospitals. A report listing the 45 most frequent diagnoses in Colorado hospitals shows 45.2 percent of admissions and 31.3 percent of inpatient days are for newborn delivery and care (Colorado Hospital Association).

Low Birth Weight Infants

According to the Department of Health, in 1984, there were 54,339 births in Colorado. The department reports that 4,141, or 7.6 percent, of these births involved infants weighing less than five and one-half pounds, and 438, or 0.8 percent, of these births involved infants weighing less than three pounds. The average length of stay for these 4,141 infants was 14 days, which totaled 58,843 patient days at a cost of $44,132,250. The average length of stay for those infants less than 1,000 grams was 89 days, for those infants less than 1,500 grams the average length of stay was 57 days, for those infants between 1,500 grams and 1,999 grams the average length of stay was 24 days, and for those infants between 2,000 and 2,500 grams the average length of stay was seven days. As this information indicates, the lighter the baby, the longer the length of stay in the hospital.

The estimated cost for low birth weight categories was calculated on an average of $750 per patient day. Neonatal costs range from $1,200 per patient day for the most intensive care, to $600 to $800 per patient day for intermediate care, and $200 to $400 per patient day for those needing minimum care. Estimates of the cost for low birth weight deliveries and care range from a high of about $104,000 per infant at 25 weeks gestation and a low of about $10,000 per infant at 34 weeks gestation.

The Department of Social Services reported that information from Medicaid cost reports show that the actual cost per low birth weight baby in 1983-84 was $28,000. There were 64 low birth weight Medicaid babies born in 1983-84 for a total cost of approximately $1.9 million.

In addition to the cost of providing health care to these premature and low birth weight infants, studies have shown that low birth weight babies and premature babies have a greater risk of special problems such as mental retardation, cerebral palsy, developmental disabilities, blindness, neurological handicaps, and epilepsy. For example, it has been estimated that four percent of the babies weighing less than three pounds, and one percent of the babies weighing between three and five and one-half pounds, will require institutional care. A substantial portion of the institutional and special education costs for these children will probably be borne by the state.

Infant mortality (the death of a live born infant under one year of age) and neonatal deaths (the death of infants under 28 days old) is associated with low birth weight and prematurity. Neonatal deaths account for about 70 percent of infant deaths. Approximately two-thirds of all infant deaths occur in infants weighing less than five and one-half pounds at birth. Major causes of infant mortality are low birth weight and birth defects.

Effectiveness of Prenatal Care

A number of factors contribute to low birth weight, including lack of or poor prenatal care, poor maternal nutrition, maternal age, bearing children at less than two-year intervals, smoking and alcohol and drug use and abuse, and social and economic background. However, a substantial amount of evidence indicates that a lack of prenatal care can contribute to women delivering low birth weight babies and that high quality prenatal care begun early in pregnancy can lower the incidence of low birth weight. Given no prenatal care, an expectant mother is three times more likely to deliver a low birth weight child. A recent report by the Department of Health (August, 1985) noted that, in 1984, approximately 524 of the 54,339 women who gave birth that year received no prenatal visits. Of these women, 21.8 percent gave birth to low birth weight babies, compared to 6.2 percent for women receiving eight or more prenatal visits. Approximately 8,049 of the women giving birth that year received from one to seven prenatal visits. Of these women receiving from one to seven prenatal visits, 14.6 percent gave birth to low birth weight babies, compared to 6.2 percent for women receiving eight or more prenatal visits.

Prenatal care helps insure that: 1) the expectant mother maintains good health and proper diet; 2) any medical or other problems are detected early and promptly managed; and 3) the expectant mother is educated about health care and nutrition during pregnancy and childbirth. According to American College of Obstetricians and Gynecologists standards, a pregnant woman should begin prenatal care

during the first trimester and ideally should be seen at least once every four weeks for the first 28 weeks of pregnancy, every two to three weeks until the 36th week, and weekly thereafter. Women with health problems should be seen more frequently. Local studies have found that Colorado women who have the 13 prenatal visits recommended have a prematurity birth rate of less than five percent, while those who receive no prenatal care have a prematurity rate of approximately 28 percent. A 1977 study by the Department of Health indicates that 54 percent of low income women in Colorado received no prenatal care during the first trimester of their pregnancies, as compared with 80 percent of higher income women. Other studies show that lower income women are more likely to have a high-risk pregnancy.

The precise extent of unavoidable premature births is not known, although it is estimated to be approximately two to three percent of all deliveries. With the incidence of premature births in Colorado and in the United States estimated to range from approximately six to eight percent of all deliveries, there is much interest in attempting to reduce the percentage of premature and low birth weight babies and thereby reduce neonatal hospital costs for such infants, as well as reduce the longer term costs associated with developmental disabilities, neurologic handicaps, and mental disorders. In this regard, the committee began an examination of the cost-effectiveness of a prenatal program to be funded and operated by the state in order to determine if such a program would assist in containing health care costs associated with low birth weight and premature babies. In other words, the committee sought to answer the question of whether a program to provide more prenatal care will reduce the chances of low birth weight babies, which in turn will reduce the number of intensive care days required to care for low birth weight babies.

Department of Health Estimate -- Cost-Effectiveness of Prenatal Care

As indicated by the Department of Health, approximately 524 of the 54,339 women who gave birth in 1984 received no prenatal visits. Assuming that the 524 women who had no prenatal visits in 1984 could be moved into a category where they would receive up to seven visits, and assuming that the cost per prenatal episode in the public health system averages $450, the department estimates that the cost to the state to provide minimal prenatal care to these women would be approximately $235,800. The $450 per prenatal episode consists of $250 from the general fund or from the maternal and child block grant funds and $200 from the patient contribution or from the county or other agency contribution.

The Department of Health noted that it is unrealistic to expect to identify and provide prenatal care to all of the 524 women by expanding the prenatal care program. However, if 100 of the 524 women with no prenatal visits could be moved into a category with some prenatal visits, five fewer babies in the three pound to five and one-half pound category could be expected and two fewer babies in the three pounds or less category could be expected. At $750 per patient

day times the number of patient days, a savings of $125,000 could be expected. If 100 women in the one to seven prenatal visits category could be moved into the eight or more visits category, a reduction in hospital patient days worth approximately $200,000 could be realized. By moving 200 of the 524 women into categories with more prenatal care, a savings of $308,250 could be achieved. To achieve this savings, an overall investment of $225,000 would have to be made ($450 per episode times 500). The investment of state money would be $125,000 ($250 per episode times 500).

Department of Social Services Estimate -- Cost-Effectiveness of Prenatal Care

In an effort to develop an effective prenatal care program, the committee examined several proposals. The Department of Social Services reported that there are 1,000 pregnant women who are at 60 percent of the poverty level and who qualify for Medicaid. These are women who work under 100 hours per month. However, there are 1,590 pregnant women who are also at 60 percent of the poverty level but who work over 100 hours per month and who are thus not covered by Medicaid. These women could be covered under a medically needy expansion to the Medicaid program. Since these women would become categorically eligible, they would have to receive the entire Medicaid package of benefits under the medically needy Medicaid option. These benefits include prenatal services, delivery services, and other medical services such as hospital inpatient and outpatient services, physician services, and prescription drugs when ordered by a physician. The department estimated that the cost to cover the 1,590 pregnant women in this category with a total Medicaid benefit package is approximately $3,560,685. Delivery services under the Medicaid program average $1,550 per person. For 1,590 pregnant women, these costs would equal $2,464,500 ($1,550 times 1,590 women). Approximately one-half, or $1.75 million, would be the state share of the cost of such a program. If the state were to invest in such a program, the department estimated that the state could achieve a savings of $1.2 million (one-half of a $2.4 million savings in the cost of Medicaid services to children, ages zero to three, of these 1,590 women) and a $1.0 million savings in a set-off against the Medically Indigent program, for a total savings of $0.45 million ($2.2 million savings minus $1.75 million state investment).

If the state were to provide prenatal care services to these same 1,590 pregnant women through the Medically Indigent program, the Department of Social Services estimated the cost at $700,000. Prenatal services would not include delivery and other medical support services which would continue to be provided by the Community Maternity program and Medically Indigent hospital care program, or would remain uncompensated care. The savings to the state would amount to $1.2 million (one-half of a $2.4 million savings in the cost of Medicaid services to children ages zero to three, of these 1,590 women), for a total state savings of $0.5 million ($1.2 million savings minus $0.7 million investment). The estimated savings of $2.4

million ($1.2 million state share) is based upon medical cost savings for the children born to the 1,590 pregnant women during only their first year of life. Additional savings may be expected in future years.

The Department of Social Services also estimated that there are 1,050 women who are at 66 percent of the poverty level and who are not now covered by Medicaid. The department estimated that these pregnant women could be provided services through an expanded medically needy category to the Medicaid program at a cost ranging from $2,122,988 to $2,351,396. The range of services to these women could be limited to some extent as they would not become categorically needy if the Medicaid program was expanded to provide services to them. The estimated cost would be shared approximately 50 percent by the state and 50 percent by the federal government.

Colorado Task Force on the Medically Indigent Recommendation

The Colorado Task Force on the Medically Indigent, in 1984, estimated that there are approximately 12,000 low income uninsured pregnant women under 150 percent of the poverty line. The Task Force estimated that approximately 4,000 of these women are currently eligible for Medicaid but are not enrolled. The Community Maternity Program covers approximately 1,600 low risk deliveries for the 12,000 low income uninsured pregnant women below this income level. It was also estimated that Denver Health and Hospitals and University Hospital covered over 2,000 low and high risk deliveries.

The Task Force recommended expansion of the medically needy Medicaid program to cover approximately 1,000 pregnant women who fell within the medically needy "band". Persons can become eligible as medically needy by having their incomes fall within the narrow band between the AFDC payment level (60 percent of poverty) and 133 percent of the AFDC level (66 percent of poverty). Persons can also become eligible if their income falls below that upper level after deducting medical expenses from income, a process that is called "spending down". It was estimated that 500 pregnant women in the medically needy eligibility "band" would enroll in Medicaid. It was also estimated that of the 5,500 uninsured pregnant women with incomes between 66 percent and 100 percent of poverty, 550 would be expected to enroll in Medicaid by spending down. The estimated cost of covering these 1,050 pregnant women through Medicaid services was estimated at $2,000 per case, or a total of $4.4 million.

The Task Force also recommended that the state increase funding to cover approximately 4,000 pregnant women not eligible for Medicaid or served by another program. Of the 12,000 low income uninsured pregnant women, 4,000 who are eligible for Medicaid but not enrolled were subtracted, 1,000 who would be covered as medically needy pursuant to the above recommendation were subtracted, and 1,800 pregnant women under eighteen who would be covered as medically needy children were subtracted. Among the 5,200 remaining target

population, a 74 percent participation rate resulted in a projection of 4,000 pregnant women. The Task Force recommended expanding the Community Maternity Program to: 1) pay for prenatal care; 2) cover more deliveries, not just those of low risk; and 3) cover the approximately 4,000 more women under the 150 percent poverty line. The estimated cost of this program is $7.1 million ($2,000 per case and graduated cost sharing) of state funds.

The Task Force did not estimate the cost savings to the state from expanding the Medicaid program to medically needy pregnant women or from expanding prenatal care and delivery services to medically indigent women. It was believed that some persons now receiving care funded by the Medically Indigent program, particularly the lowest income pregnant women served through the Medically Indigent program, would be eligible for an expanded Medicaid program. It was also believed that state general funds could be saved by providing prenatal care to low income women and thereby preventing fetal disability and the high costs to serve disabled children in institutions for the mentally disabled under Medicaid and care in state-funded community centers and special education programs.

~~Other Estimates of Cost-Effectiveness of Prenatal Care~~

Other estimates on the cost-effectiveness of a prenatal care program vary. One estimate is that for every one dollar spent on high quality prenatal care, which can prevent low birth weight and premature babies and the consequent high neonatal cost, nine dollars can be saved in hospital care and eleven dollars can be saved in long-term costs for developmentally disabled children. Recent techniques in the treatment and care of women with high-risk pregnancies have developed which can stop premature birth effectively in order to allow the development of the lungs. Lung maturation is very important in the development of a fetus, since respiratory distress and lack of oxygen after a premature birth can cause mental and physical disabilities. As birth weight increases and the lungs mature, the lowering of neonatal costs can be achieved. One study noted that the average cost of hospital care per premature infant is about $772 per day. The average in-hospital cost per day for women admitted because of threatened premature delivery is about $310. Thus, for every additional day the infant spends in utero, a savings of $426 per day is achieved. Once pregnancy has advanced as far as 29 weeks, successful postponement of premature delivery offers very significant financial rewards. In-hospital cost of care declines so rapidly between the 29th and 34th week of gestation that there are financial benefits to delaying delivery by days.

Committee Recommendation

Concerning the Medical Expenses of Qualified Children and Pregnant Women -- Bill 18. In an effort to expand the delivery of prenatal care to low income uninsured pregnant women, the committee

recommends Bill 18. Bill 18 makes a $700,000 appropriation to the University of Colorado Health Sciences Center, as the Medically Indigent program administrator, to provide prenatal care to medically indigent pregnant women. The committee determined that by designating specified funds to be targeted to a particular service for a specified population, the state may be able to achieve cost savings in terms of avoiding high costs associated with the neonatal care of low birth weight infants and premature infants. This approach allows the state to control the costs directly by establishing the amounts designated for such a program in accordance with available dollars. It was believed that an expansion of the medically needy option under Medicaid to cover pregnant women who fell into the medically needy "band" would not reach many of the other medically indigent pregnant women, and that such an expansion of Medicaid would require the provision of the full Medicaid package of benefits.

Motorcycle Helmet Legislation

Background

In 1977, the General Assembly repealed the mandatory motorcycle helmet use law. Since 1976, more than 35 states have either repealed or significantly altered mandatory helmet usage legislation. Various studies conducted since 1976 reveal significant increases in head injuries, deaths, medical costs, and days of disability since the repeal of such laws. Unhelmeted motorcycle accident victims sustain a greater number of and more severe head injuries and experience a higher fatality rate than helmeted victims.

Committee Activities

A particular concern of the committee involved the additional medical care costs associated with the increase in frequency and severity of head injuries which might have been overted if the helmet law had not been repealed. Various studies have arrived at the following conclusions:

- -- unhelmeted riders are likely to be more seriously injured than a helmeted rider;
- -- unhelmeted riders spend more time hospitalized than helmeted riders;
- -- unhelmeted riders incur greater medical expenses than helmeted riders; and
- -- the amount of permanent disability is significantly increased when helmets are not worn.

In addition to medical costs, there are also other direct costs such as legal expenses, funeral expenses, insurance administration, police investigation, and employer losses. Various studies have found that a substantial percentage of the medical care costs are not paid

by the injured motorcycle accident victim and are therefore absorbed by other hospital users and the public generally. For example, in a study of 71 motorcyclists admitted to Denver General Hospital from July, 1976 to June, 1977, only 38 percent were covered by commercial insurance or workmen's compensation benefits. It was found that 25.5 percent of the costs were paid from the Medically Indigent program and 32.2 percent of the costs were unpaid. Thus, approximately 58 percent of the unpaid bills were borne by other hospital users and taxpayers.

Committee Recommendations

Concerning Safety Requirements for Motorcycles and Motor-Driven Cycles -- Bill 19. Since a substantial number of motorcycle accident victims are uninsured and a sizable portion of these medical care expenses are unpaid, the taxpayers' burden of funding these additional expenses is significantly increased. In an effort to reduce the number of such accident victims which rely on Medically Indigent program funds to pay for necessary medical care, the committee recommends Bill 19, which reinstates the mandatory motorcycle helmet law.

Bill 19 requires any person operating a motorcycle on the state's public highways to wear a protective helmet. Any person who violates this provision commits a class A traffic infraction. The bill specifies standards for protective helmets and provides that helmets with face shields satisfy the requirement that motorcycle operators and passengers wear goggles or eye glasses.

Continuation and Conversion of Health Insurance Benefits

Background

Private health insurance has grown rapidly in recent years to become the primary mechanism of financing medical care in the United States. Since the 1940's the predominence of employment-related group health insurance plans has been firmly established. Persons moving away from employment-related insurance face high premiums, limited coverage, and stringent exclusions. Because most private health insurance is employment-related, loss of employment often means a loss of health insurance coverage. In addition, spouses and dependents of covered employees may lose their insurance coverage because of death or divorce. Continuation and conversion of group health insurance benefits are two short-term strategies for providing some sort of health coverage.

Conversion

Conversion privileges offer persons who have lost their eligibility for group insurance because of job termination, divorce, or the death of a covered spouse the opportunity to convert to nongroup coverage. Conversion policies are usually less comprehensive and more expensive than group benefits. The National Association of Insurance Commissioners (NAIC) issued a model law outlining provisions for mandatory conversion privileges in 1975. In 1982, 16 of the 32 states with conversion statutes (including Colorado) conformed to the NAIC Model Act while the remaining states also followed NAIC guidelines in varying degrees (Intergovernmental Health Policy Project).

The NAIC model is applicable to persons insured under group hospital, surgical, and major medical expense insurance programs. The model provides for the delivery of individual policies at standard rates based on the age and class of risk of the insured, and the form and amount of insurance. An insurer is not mandated under the model act to offer a converted policy which provides higher benefits than the original group policy. However, the converted policy may not exclude a preexisting condition not excluded by the group policy. The model act provides for a specific plan to be offered upon conversion and allows an insurance company the option of continuing a subscriber's group coverage in lieu of conversion to an individual policy.

A report by the Intergovernmental Health Policy Project indicates that, in 1985, 31 states have conversion provisions. Five states (California, Ohio, Rhode Island, South Dakota, and Virginia) provide for conversion only upon job termination, while the remaining 26 states also provide for conversion policies upon layoffs. Currently, Colorado statutes do provide for conversion benefits (10-8-116 (3), (4), and (5), C.R.S.). These provisions were added to the law in 1975 and follow NAIC guidelines. Colorado law also requires that the conversion privilege be available to surviving spouses after the covered employee's death, to spouses who have been divorced from covered employees, and to dependants of covered employees.

Continuation

Continuation rights give an employee, dependent, surviving, or divorced spouse the right to purchase continued medical coverage at the employer's group rates for an established period of time after an employee's separation from service. Although state laws differ, for the most part state continuation legislation has included the following provisions:

1) individuals have a specified number of days to exercise their continuation option;

2) eligibility is limited to persons who had been continuously covered by a group policy for a specified period of time preceding coverage termination;

3) continuation is not required if the individual is eligible for or covered by another similar policy; and

4) the person electing to continue coverage pays at the former group rate but must also pay the employer's share of the premium.

A study done by Hewitt Associates, a firm specializing in employee benefit consulting, indicates that 23 states have laws allowing for insurance coverage continuation rights for separated employees, dependents, and spouses. In most cases, these laws only cover insured plans; however, four states (Iowa, New Hampshire, Ohio and South Dakota) require self-funded medical plans to include continuation benefits as well. The Hewitt study indicates that almost two-thirds of the states' continuation statutes have been passed since 1980. Some states have limited this privilege to only laid-off or only terminated employees. Current Colorado law does not require health insurance policies to offer continuation privileges.

Committee Recommendations

Concerning Health Benefit Plans, and Providing for Continued Coverage Upon Termination of Employment -- Bill 20. In order to provide some sort of health insurance coverage to terminated employees, the committee recommends Bill 20 which requires all group sickness and accident insurance policies issued by commercial insurers, all group contracts providing hospitalization or medical benefits for subscribers issued by a hospital or health service corporation, and all group service contracts providing health care services for enrollees issued by health maintanence organizations, to provide for continued coverage of an employee, upon termination of his employment for a period of one year or until he becomes reemployed, whichever is shorter. The bill further requires that such policies or contracts provide that, upon expiration of the continued group coverage, the employee or his spouse or dependent, at his option and expense, may elect to obtain individual coverage without further evidence of insurability and without interruption of coverage.

When an eligible employee's employment is terminated, the employer is to notify the employee of his right to continue coverage immediately upon his termination. The employee is required to make the necessary payments to the employer or other administrator of the plan. If timely receipt of payment is made and the employer or administrator of the plan fails to make payment to the plan provider, with the result that the employee's coverage is terminated, the employer or administrator is liable for the employee's coverage.

INSURING UNINSURABLE PERSONS

Introduction

Although many people have adequate health insurance through their employer, there are a number of persons in the United States who are unable to purchase adequate coverage because of preexisting health conditions. These persons may be employed by an employer who offers minimal health benefits, or they may have been insured at one time and have become uninsurable when they became unemployed and lost their group coverage or when their spouse with employer-provided health benefits has died. Insurers often find it undesirable to offer coverage to these people or may offer very expensive coverage as their poor health status is indicative of expected medical expenditures the insurers would have to cover. Providing health insurance for people who are unable to obtain adequate coverage because of preexisting health conditions is a major concern throughout the states; such coverage can determine whether an individual or a family will be faced with the possibility of becoming medically indigent.

Shared Health Insurance Risk Pools

Description of Health Insurance Risk Pools

State health insurance risk sharing pools are a mechanism for providing comprehensive health insurance to high risk individuals. Eight states (Connecticut, Florida, Indiana, Minnesota, Nebraska, North Dakota, and Wisconsin) have adopted insurance pool legislation. In addition, Rhode Island has established a catastrophic insurance pool. Generally, participating states have enacted health insurance pool legislation requiring all of the state's insurers to be members of the pool. Although each state's specific provisions vary, all states with risk pool statutes have established subscriber eligibility criteria and a specified set of minimum benefits. Deductibles, coinsurance, maximum liability, maximum lifetime benefits, and waiting periods for preexisting condition coverage are included in the state's provisions.

Financing of state risk pools is complicated by the high risk nature of the persons covered by pool insurance. Although part of a pool's financing is through subscriber premiums, states have restricted the cost of premiums charged to subscribers in order to provide broader access to coverage. If a state has made a policy decision to cap a pool's premiums at affordable levels and to limit pool coverage to high risk persons, it cannot expect the pool to be self-supporting. The losses incurred each year by the pool can be made up by direct public subsidy or by indirect assessments on participating insurers. The latter is usually accomplished by assessing each insurer based on their percentage of the annual total

health insurance premiums written in the state. A state can offset this assessment by applying a credit against the amount of premium or benefits tax paid by the insurer. (This would result in an indirect public subsidy.)

The viability of the health insurance risk pool concept is founded on the participation of a broad base of member insurers. Thus, states attempt to require pool participation by every organization providing some form of medical benefits. This includes commercial insurers, nonprofit hospital and health service corporations, health maintenance organizations, fraternal benefit associations, and self-insured employers. Because assessments to fund pool losses are generally based on the amount of premiums written, and a credit given to offset the annual premium tax paid by the insurer, states have also considered expansion of premium tax collection to all participating groups in order to provide a broad financial base for the pool. A potential barrier to creation of a broad base for a risk pool is the existence of self-insured employer groups. Self-insured employer groups constitute a sizable share of the health insurance market and state regulation of such groups is limited by federal law.

Federal Preemption of State Insurance Regulation

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) which limits the states' authority to regulate employee benefit or employee welfare benefit plans. Court rulings in Wisconsin and Connecticut have found that state laws requiring the participation of self-insured employee benefit plans in risk pools and the assessment of self-insured employee benefit plans to fund risk pools to be preempted by ERISA. A recent decision by the United States Supreme Court has also attempted to clarify a state's regulatory authority with regard to ERISA-protected insured and self-insured employee benefit plans.

Assessment of self-insurers under risk sharing pool act -- Wisconsin. In 1979, the state of Wisconsin enacted a statute establishing a health insurance risksharing plan for the benefit of Wisconsin residents who were unable to secure ordinary health insurance coverage (Wisconsin Statutes, 619-10 et. seq). Both insurers and self-insurers were to share in the operating and administrative expenses of the plan. Section 619-14 (b) (2), Wisconsin Statutes, provided as follows:

> If the participating insurer is a self-insurer or a provider of health insurance coverage under a medical reimbursement plan, the participating insurer's share in the operating and administrative expenses of the plan shall be proportional to the ratio of the sum of the total benefits paid and the total administrative costs incurred during the preceding calendar year to residents to the aggregate cost of premium, subscriber contract and health maintenance organization charges, and self-insurance and medicare

reimbursement charges received by all participating insurers on health insurance business written in this state on behalf of residents during the preceding calendar year, as determined by the commissioner.

Subsequent to the enactment of this law, the Commissioner of Insurance took steps to implement the law as applied to several "employee welfare benefit plans." The plans brought suit in the United States District Court, Eastern District, Wisconsin (General Split Corporation v. Mitchell, 523 F.Supp. 427 (1981)), seeking declaratory judgment and permanent injunction against application of the law to such employee welfare benefit plans. The plaintiffs contended that the regulatory scheme embodied by the Wisconsin law was preempted, as to them, by the Employee Retirement Income Security Act, 29 U.S.C. 1001, et seq. Conversely, the defendants (Wisconsin Commissioner of Insurance) argued that the law was a valid exercise of the state's authority to regulate the sale of insurance. The defendants based their argument on the fact that none of the plaintiffs' plans were fully self-insured. Instead, each plan had stop-loss coverage with an outside insurance company. The defendants contended that it was well within their authority to regulate the stop-loss carriers, and thus regulate the plaintiffs' plans which had contracted with these carriers.

The United States District Court determined that ERISA preempted any state law that "relates to" employee benefit plans, and that such plans are not deemed to be insurers covered by the state's insurance regulations. The defendants contended that the contribution to the risk sharing plan mandated by the law was simply a premium tax to be paid by the stop-loss carriers on the premium paid by the plaintiff's plan. However, the plaintiffs successively argued that this was not correct. The assessment under the law was to be paid by the plans based on the total benefits paid; it was not limited only to an assessment on the stop-loss premium. The court ruled that the plans themselves were taxed and were required to contribute to the risksharing plan and that ERISA had preempted this type of regulation. The court further enjoined the defendants from enforcing the provisions of the Wisconsin law.

Taxation of benefits paid by an employee welfare benefit plan -- Connecticut. In 1971, the state of Connecticut enacted a statute which imposed a tax on employee welfare benefit plans (Connecticut General Statutes, 12-212b and 12-212c (Supp. 1978)). That statute required the "organized group maintaining the plan" to pay an annual tax of 2.75 percent on "the amounts paid as benefits to or on behalf of the residents of Connecticut during the preceding calendar year." The Connecticut Tax Commissioner attempted to assess and collect this tax in 1977. The National Carriers Conference Committee and eleven individual members as fiduciaries of the Railroad Employees National Dental Plan brought an action in the United States District Court, Connecticut, for declaratory and injunctive relief against the assessment and collection of the Connecticut tax.

In National Carriers' Conference Committee v. Heffernan, 454 F.Supp. 914 (1978), the plaintiff argued that the state's power to tax an ERISA-covered plan was preempted by ERISA (29 U.S.C. 1144 (a)), which provides that the provisions of ERISA "supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan..." Defendants argued that state taxation is not preempted by ERISA because congressional concern focused on state "regulation," and taxation is not regulation. Furthermore, the preemption provision should be read narrowly because preemption of a state's taxing power is not necessary to accomplish ERISA's objective of insulating plans from potentially conflicting state regulatory requirements. The court found that the language in ERISA clearly indicates an intention to reach every state statute that fits the description of "relating to" an employee benefit plan. The tax imposed by the Connecticut law is such a statute. The statute is not merely a general taxing provision that catches employee benefit plans within its scope, but is specifically directed at such plans exclusively; the statute clearly "relates to" ERISA-covered plans. The court found that the power to tax entails the power to regulate as well and the potential use of taxation as a means of regulation requires that ERISA preempt the state law. The court found the statute void and unenforceable and enjoined the tax commissioner from the assessment and collection of such tax.

State insurance regulation as applied to employee welfare benefit plans -- United States Supreme Court. In 1976, Massachusetts enacted a statute which required that specified minimum mental health care benefits be provided a Massachusetts resident who is insured under a general insurance policy, an accident or sickness insurance policy, or an employee health care plan that covers hospital and surgical expenses (Massachusetts General Laws Annotated, chapter 175, section 47B, West Supp. 1985). In particular, section 47B required that a health insurance policy provide 60 days of coverage for confinement in a mental hospital, coverage for confinement in a general hospital equal to that provided by the policy for nonmental illness, and certain minimum outpatient benefits.

Metropolitan Life Insurance Company and Travelers Insurance Company (insurers) issued group health policies to employee benefit plans, and to employers or unions that employed or represented employees in Massachusetts. Under the terms of section 47B, both companies were required to provide minimal mental health benefits in policies issued to cover Massachusetts residents. In 1979, the Attorney General of Massachusetts brought suit in Massachusetts Superior Court for declaratory and injunctive relief to enforce section 47B, asserting that the insurers had failed to include the benefits mandated by that section, and that they refused to provide these benefits, in part on the ground that they believed ERISA preempted section 47B. The court was asked to require the insurers to provide the mandated benefits to all covered residents subject to the terms of section 47B. The Superior Court issued a preliminary injunction requiring the insurers to provide the mandated coverage. A permanent injunction to the same effect was later issued.

The insurers sought appellate review from the Supreme Judicial Court of Massachusetts, which review was granted. In 1982, the judgment of the Superior Court was affirmed (Attorney General v. Travelers Ins. Co., 385 Mass. 598, 433 N.E. 2d 1223). The Supreme Judicial Court of Massachusetts determined that section 47B is a law "which regulates insurance," as understood by the ERISA saving clause (29 U.S.C. 1144 (b) (2) (A)), and therefore is not preempted by ERISA.

The insurers appealed to the United States Supreme Court in 1983 and the United States Supreme Court vacated the judgment of the Supreme Judicial Court and remanded the case for further consideration (463 U.S. 1221). Upon remand, the Supreme Judicial Court reinstated its former judgment (Attorney General v. Travelers Ins. Co., 391 Mass. 730, 463 N.E. 2d 548 (1984)). The insurers once again appealed to the United States Supreme Court. On June 3, 1985, the United States Supreme Court held that the Massachusetts mandated benefit law is a "law which regulates insurance" and so is not preempted by ERISA, insofar as the Massachusetts law applies to insurance contracts purchased for employee benefit plans subject to ERISA. The judgment of the Supreme Judicial Court was therefore affirmed (Metropolitan Life Insurance Co. v. Commonwealth of Massachusetts, 53 L.W. 4616).

The United States Supreme Court decision results in a distinction between ERISA-protected insured plans and ERISA-protected uninsured (self-insured) plans, leaving the former open to indirect state regulation while the latter are not. The applicable sections of ERISA which allow indirect state regulation under certain circumstances are 29 U.S.C. 1144 (a) and 29 U.S.C. 1144 (b) (2) (A) and (B) and read as follows:

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4 (a) and not exempt under section 4 (b). This section shall take effect on January 1, 1975.

(b) Construction and application. (2) (A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4 (a), which is not exempt under section 4 (b) (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any state purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Section 47B, although clearly relating to benefit plans governed by ERISA and thus falling within the reach of ERISA's preemption provision (29 U.S.C. 1144 (a)), regulates the terms of certain insurance contracts and is saved from ERISA preemption by the saving clause as a law "which regulates insurance" (29 U.S.C. 1144 (b) (2) (A)). The court determined that the language of the subsequent subsection, (2) (B), reinforced this opinion by explicitly stating that employee benefit plans are not deemed to be insurance companies for the purpose of state regulation.

> By exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause. Unless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans (53 L.W. 4620).

Thus, if a state law "regulates insurance", as mandated benefit laws do, and does not apply directly to benefit plans, the court determined that it is not preempted by ERISA.

Committee Recommendations

Concerning the "Colorado Health Insurance Pool Act" -- Bill 21. After considerable discussion and testimony from advocates of state-established health insurance risk pools and members of the insurance industry, the interim committee recommends Bill 21 to establish a health insurance risk pool. A ten-year projection of the cost to the state to operate a risk pool was presented to the committee by Communicating for Agriculture, a nonprofit organization established to advocate the family farm and rural way of life. Their projection is based on the following factors:

- -- state population projections from the Bureau of Census;
- -- operating statistics from states with established pools;
- -- projected number of individuals in Colorado with a serious illness;
- -- use of a standard plan ($500,000 lifetime benefit, twenty percent copayment, $250 deductible);
- -- inclusion of mental health benefits;
- -- current claims paid in Colorado; and

-- the state's current claims/loss ratio.

The projection indicates that the first year cost to the state above income to operate the pool would be $67,500, the fifth year cost would be between $1.4 million and $1.5 million, and the tenth year cost would be between $5.2 million and $6.5 million. Communicating for Agriculture also projected that after ten years of operation, the cost to operate the pool above the income generated by subscribers would only increase by the annual percentage increase in the state's population.

Bill 21 adds a new part to the insurance statutes, creating a state health insurance risk pool to make health insurance coverage available to residents of the state who are otherwise considered uninsurable. The bill states that all health care financing mechanisms (commercial insurers, self-insurers, nonprofit health service corporations, and health maintenance organizations) are to be assessed as pool members to fund the operation of the pool.

Any resident of the state is eligible for pool coverage if they have been refused health coverage for health reasons, can only acquire health coverage with an exclusion for a preexisting health condition, or can only acquire health coverage at a rate exceeding the pool rate. Bill 21 provides that the risk pool premium rate is not to exceed 200 percent of standard risk rates. The risk pool policy has a lifetime limit of $500,000 per individual and includes a choice of deductible amounts and coinsurance of twenty percent. In addition, the bill lists those services which are covered by the pool policy and those services which are not included for coverage.

The pool is funded by an assessment on each participating insurer and self-insurer. The assessment is based on the insurer's share of the total of all premiums and subscriber contract charges during the calendar year, and on the self-insurer's share of the total of all benefits paid to employees by self-insurers. Insurers and self-insurers not participating in the pool shall pay a fee based on the gross premiums on health benefits paid or provided in the state for the last calendar year. Pursuant to Bill 21, any insurer subject to tax liability imposed by section 10-3-209, C.R.S., (premium tax) may offset 100 percent of the assessments paid to the pool.

Concerning the Taxation of Health Care Financing Plans -- Bill 22. In addition to recommending the establishment of a health insurance risk sharing pool, the committee recommends Bill 22 which expands the taxation of earned premiums and paid benefits. Currently, only commercial insurers are liable to the state for premium taxes (section 10-3-209, C.R.S.).

Bill 22 expands the taxation of earned premiums to include insurance coverage by fraternal and benevolent associations, nonprofit hospital and health service corporations, and health maintenance organizations. The bill also taxes self-insurers on the basis of benefits paid to or on behalf of employees covered by the self-insured

company's plan. Earned premiums received for coverage of health, sickness, or accidents which are supplemental to Medicare coverage are not taxable. Bill 22 requires foreign group insurers providing health insurance coverage for Colorado residents to pay pro rata premium taxes based on the amount of earned premiums received from providing such insurance.

At the request of the committee, the office of the Commissioner of Insurance prepared an estimate of the projected income payable to the state if all Colorado health maintenance organizations and nonprofit health and hospital corporations (Blue Cross and Blue Shield, for example) were made subject to the provisions of the premium tax (10-3-209 (1) (b), C.R.S.). There are currently four nonprofit health and hospital corporations, and one for-profit and six nonprofit health maintenance organizations operating in Colorado. In 1984, the total tax payable by all of these companies would have been $4,051,135. The Blue Cross and Blue Shield portion of this amount would have been $1,852,388.

The Insurance Commissioner's office also noted that, in all probability, section 10-3-209 (1) (c), C.R.S., which waives all state taxes except real estate and worker's compensation for those insurers subject to the premium tax requirement, would supersede section 10-16-123, C.R.S., which requires a payment of five cents per person covered exceeding ten thousand persons covered by all nonprofit health and hospital corporations. The total amount paid to the state for all four corporations in 1984 was $22,138. Therefore, the total net increase to the state's general fund for the inclusion of all health maintenance organizations and nonprofit health and hospital corporations in the premium tax requirement, while excluding them from corporate income tax and subscriber fees, would have been $3,883,279 for 1984.

LONG-TERM HEALTH CARE

Background

Demographic Trend

Demographics. For sometime various government agencies, particularly the Census Bureau, have made projections for future life expectancy and the size of the older population. These projections suggest significant future increases in life expectancy and a large increase in the number of elderly as a percentage of the population. In the last major census in 1980, there were 25.9 million Americans ages 65 and over -- 11.1 percent of the population. By the year 2040, when all remaining "baby boomers" (those born in the nineteen-year period from 1946 to 1964) will be in their older years, it is projected there will be 67.3 million people ages 65 and older -- 20.5 percent of the population.

By the year 2000, 13.1 percent of Americans will be over 65 years of age. Six and one-half percent will be over 75 years of age. By the turn of the century, the 75-85 age group will increase from 7.7 to 12.2 million, while the 85 and over population will more than double, from 2.2 million to 5.1 million. The Census Bureau projects that the number of people 85 and over will grow by more than twenty percent during this decade (compared with ten percent increase for those of all ages). The over-85 population will increase three to four times faster than the population at large during the following two decades.

During 1983, there were 270,000 persons in Colorado over the age of 65, or 8.6 percent of the total state population. This represented a 9.4 percent increase in this population group since 1980. It is estimated that 12.8 percent of this population are below the poverty level.

Mortality. Decreasing mortality rates have had and will continue to have a significant impact on the need for long term care. Based on mortality experience in 1900, an individual born in that year could expect to live an average of 47.3 years; by 1982, life expectancy reached 74.5 years. From 1940 to 1980, the age-adjusted death rates for the elderly decreased by 38 percent. About half of the overall decline in mortality among the elderly during this period resulted from the decline in heart disease mortality and another quarter is associated with the fall in the death rate for strokes. Contributing factors include improved medical services, greater availability of coronary care units, advanced surgical and medical treatment of heart disease, improved control of blood pressure, decreased smoking, increased exercise, and healthier life styles in general.

Use of health care services. The incidence of chronic illness increases with age and becomes a major cause of disability requiring medical care. Since the need for help increases sharply with age, the very old have more need for assistance than the younger-old. Older persons with chronic and disabling conditions are high users of medical resources. Studies show that elderly people make more frequent visits to physicians, are hospitalized more frequently, and stay in the hospital longer than younger people.

The rate of long term care utilization also increases dramatically with age. For individuals over 85 years of age, the rate is 23 percent; for the 75 to 85 years of age, the rate is six percent; for the 65 to 74 age group, the utilization rate is two percent. About five percent of all elderly compared with about 23 percent of the very old (85 years and over) are in nursing homes. Other chronically ill elderly persons are in psychiatric or other chronic disease hospitals, veteran's administration hospitals, and other long term care facilities.

The impact of the aging of the population from 1980 to 2000 on the health care system of the United States is projected to increase, by 28 percent, the days of hospital care required. The total number of physician visits is projected to increase nineteen percent, and the

number of nursing home residents is projected to increase 69 percent. There are regional variations to these projections. In the South and West, where the elderly will increase 60 percent, it is projected the number of nursing homes will have to more than double to meet the needs of the projected elderly population.

Expenditures For Long Term Health Care

Nationally, expenditures on nursing homes have increased significantly over the past decade. Nearly half of those costs, more than $14 billion a year, are now borne by the states and the federal government, not primarily through Medicare, but almost entirely through Medicaid. Since Medicaid's adoption, national nursing home expenditures have increased, growing from $480 million in 1960 to $20.7 billion in 1980. For most of that period, Medicaid spending on nursing homes increased over twenty percent per year, more than twice as fast as total state and local spending. Medicare, on the other hand, provides health insurance coverage to most individuals 65 and over, and to others, but does not cover long term care services. There are approximately 28 million elderly and three million disabled eligible beneficiaries on Medicare. In 1983, total outlays exceeded $58 billion; of this total, 69 percent was spent on hospital services and 23 percent on physician services. Less than one percent was spent for nursing home care. Thus it can be seen that Medicaid has become the primary vehicle for the payment of long term care services in the form of nursing home expenditures. In 1983, Medicaid expenditures amounted to $36 billion.

Medicaid now pays for approximately 48 percent of all nursing home costs, and those costs account for nearly half of all Medicaid expenditures nationwide. In some states, the percentage is higher, but in nearly every state Medicaid is one of the top line-item expenditures. Currently, Medicaid appropriations are under fiscal constraints because state fiscal capacity has not kept pace with program growth. Medicaid expenditures increases have been one-third to one-half higher than the growth rate of state revenue.

In Colorado, 50 percent of Medicaid funds are spent on long term care patients. This represents 9.2 percent of the Medicaid population. The rate of growth in nursing home expenditures has been as high as the rate of growth in hospital expenditures prior to use of DRG reimbursement of Medicare (approximately 14 percent annually). Expenditures for long term care in Colorado has grown from $45,657,674 in 1977 to $110,824,944 in 1984.

In 1983, health spending for the total population amounted to 10.8 percent of the GNP. It is estimated that approximately three percent of the GNP is spent on health care services for the elderly. Many of the elderly become poor in old age and thus qualify for Medicaid. With old age, loss of a spouse, growing disability, and incomes eroded by inflation and medical expenses, they oftentimes find themselves "spent down" to a Medicaid-eligible level. Many

middle-class people enter nursing homes as private pay patients and, once their savings are depleted, qualify for Medicaid. It is estimated that approximately one-half of all nursing home residents on Medicaid are newly impoverished people who spent most of their assets and income paying for medical and nursing home care. Approximately one-half of the bills of persons currently receiving long term care services are paid by Medicaid and this percentage is expected to increase.

The obligation of supporting these necessary services is obviously a strain on state budgets. Costs are substantial at the federal level as well and a recent study concluded that the federal budget cannot support the size of the long term care outlays implied by demographic trends and projections. Cost containment efforts on the state level have focused on the Medicaid program and the overall impact of these efforts on the growing number of elderly may be significant.

Long Term Care Service Systems

Informal Support Systems

The effect of public policy and demographics on the largest source of caregivers to the elderly, the family support system, is of great concern. Families have provided crucial and irreplaceable support for many older persons. For example, it is estimated that family members provide about 60 to 80 percent of the care received by the disabled and elderly. Many families today are under considerable stress as they seek to remain intact and to cope with the problems associated with caring for an elderly person. The "baby boomers" who will approach old age in the future may face a different situation than existed in the past or exists today. First, they are having smaller families or not having children at all. The support from children in future years will be limited by the number of children they have. Second, the high divorce and remarriage rates and the often low levels of child support payments may contribute toward less financial cooperation between the generations. Third, since a longer life expectancy of "baby boomers" is anticipated, it will become more difficult for the children of elderly parents to care for them. It may be a different situation for 45-year olds to care for their 65-year old parents than for 65-year olds to care for their parents.

The availability of services to assist families in their caregiving role is also vitally important. Services such as respite care, home care, personal care services, preventive outpatient care, dental care, and adult care are among some of the services required to provide assistance to families who are under stress in providing care to the elderly. Middle-income elders and their families and relatives may find it difficult to find available services such as respite care and adult care even when they can afford to pay some portion of these services.

Government Support Programs

There has been some opinion expressed that Medicare's new DRG prospective payment system, which reimburses a hospital on the basis of a patient's diagnosis rather than cost and length of stay, may put some pressure on long term care nursing homes. There is a belief by some that this system may create an incentive for hospitals to release patients earlier than usual -- perhaps before they are ready. Those patients may then require a higher level of care than can be provided at home. The average length of stay in hospitals has dropped over the past number of years. For example, Colorado hospitals report a reduction in the average length of stay of 6.2 days in 1980 to 5.6 days in 1984. Whether the new reimbursement system is causing hospitals to release patients earlier, and thereby impacting the nursing home caseload, may require further investigation. Nevertheless, even without the new patients from hospitals that may be anticipated, the nursing home population is expected to grow by 57 percent by 1995 and to increase nearly three and one-half times by the year 2040, when 4.3 million elderly are expected to be in nursing homes or long term care facilities.

Alternative Service Systems

Because of the decline in birthrates after 1964, there is concern as to whether the future working age population can produce enough to support the projected increased elderly population. In addition, government sponsored programs are coming under pressure to reduce or curtail services to the elderly through budget cuts. Medicare is being cut and is expected to run out of funds in the 1990's. Social Security has pushed back the age of entitlement and further cuts in cost of living adjustments are expected. Thus, the level of support "baby boomers" can expect from major government programs and from their children (the working population of the future) may not be sufficient to meet their needs. This lesser support may be exacerbated by the increased needs of the "baby boomers" who are likely to spend more time in old age, with increased need for assistance and support of various kinds.

With government programs under increasing pressure and the emerging family perhaps unequal to the burden of maintaining care for elderly parents, there has been an increased attention focused on the role of alternative government-sponsored programs and the role of the private sector in aiding older people. Some of these alternatives are discussed below.

Home and community based alternatives. States have attempted to limit the growth of the nursing home population, and thereby reduce or limit the growth of Medicaid expenditures, by establishing home or community based programs. It is contended that many people who do not require institutional care have been placed in nursing homes because Medicaid traditionally did not cover the medical and social services that might allow them to be cared for better or at a lesser cost at

home or in the community. In 1981, the Medicaid law was changed to waive the provisions that limited Medicaid reimbursements for such services. In 1982, Senate Bill 138 was passed by the Colorado General Assembly. The bill established a home and community based program for the elderly in Colorado. A waiver was applied for from the federal government and the program was implemented in 1983. This program provides an alternative to nursing home care for the elderly, blind and disabled adults who: 1) are at risk of institutionalization; 2) are Medicaid eligible; and 3) can be served at a cost equal to or less than the average Medicaid cost for an intermediate care nursing facility.

Other alternative or support programs established in Colorado include a home care allowance program, an adult foster care program, a home health care program offered as a Medicaid service, a personal care Medicaid reimbursement program for family members of long term care clients, and an alternate care facility program which provides homemaker, adult day care and personal care services to persons who meet the necessary tests and who need supervised living and housing support, but who do not require 24-hour nursing care.

During fiscal year 1984-85, 1,953 elderly clients and 776 blind and disabled clients were served by the home and community based services program, at an average annual cost per client of $2,125, for a total cost of $5.8 million. Various evaluations and studies have examined the comparative costs of serving Medicaid long term care eligible clients in the home and community based program versus the nursing home care alternative. A 1984 University of Colorado Health Sciences Center study found that the total public daily cost of home and community based clients was $20.48, while the daily cost of nursing home clients was $28.01. It is estimated that by fiscal year 1987-88, the home and community based services program will serve 3,500 clients, at an annual average cost per client of $2,400, or an annual cost of $8.4 million.

The recommendation of the Health Sciences Center study was to continue the program since it seems to provide a less costly alternative for a number of individuals who are eligible for nursing home care. The study found that this program, in conjunction with other innovations in long term care (such as the alternative care facilities program), will assist in preparing Colorado for the new demands for long term care that are emerging due to changes in demography and methods of hospital reimbursement.

While these various alternative programs are expected to improve the quality of life for those who otherwise may needlessly be placed in nursing home institutions, the federal government, based upon some studies, says that it may be too soon to assess whether they will save money. Indeed, the study in Colorado cautioned that it may be too soon to assess the long-range impact of the program on nursing home utilization and the state Medicaid budget. It is estimated that more than 70 pecent of those requiring long term care are now receiving it outside of nursing homes. The federal government has expressed

concerns that these alternative service programs will service many people who previously would have been taken care of at home without public assistance. Other studies have indicated that these services have not reduced nursing home or hospital use or total service costs. The federal government has issued a new set of regulations to subject waiver programs to more scrutiny and cost restraints.

An increase in the development of community based service programs has been reported across the nation. Some are being promoted as more humane approaches to the care of the elderly, others are being promoted as lower cost alternatives. It is speculated now that the use of DRGs for hospital reimbursement may encourage the development of home health care agencies to speed hospital discharge. These various alternatives are possible approaches to meeting the needs of the growing elderly population.

Changing the tax system to allow for tax deductions. Under the current federal tax system, an individual cannot claim a "tax deduction" when contributing to the cost of health services for a relative who is not a member of his household. As a consequence, families and individuals may be discouraged from contributing to the cost of caring for a parent or other relative, even if such care would allow the person to remain in his home and avoid going into a nursing home. Whether state and federal tax systems can and should be changed to encourage people to share in the costs of caring for their parents or other relatives by allowing them to claim such expenses as a tax deduction, is a question which may require further examination. Such a system may help reduce the number of elderly who may enter nursing homes unnecessarily and, at the same time, aid the family.

Employer-mandated long term health insurance coverage. As a method of reducing public expenditures for long term care services, it has been suggested that the government mandate the inclusion of long term care services as part of employer-based health insurance. For those employers who also offer supplemental health insurance coverage to their retired employees, it has been suggested that the government mandate that certain long term care benefits should be included as part of their health insurance policy. Such supplemental benefits could be used as the primary payer and thereby allow for reduced governmental expenditures for long term care services.

Individual health insurance accounts. Currently, many citizens have chosen to open what is commonly called an IRA -- an Individual Retirement Account. An idea similar to IRAs has been discussed for some time, i.e., allowing people to also establish an IMA, or Individual Medical Account. An IMA would allow, and more importantly may encourage, people to put money into a specific account that could not be drawn on until their retirement or upon reaching a certain age. Its purpose would be to allow people to plan for health care needs upon retirement or upon reaching a certain age that might not be provided by Medicare or any other government financed program. In addition, an IMA concept is designed to encourage a person to assume a greater personal responsibility for his own health and welfare and not

to look to the government for assistance. It is thought that such a system could be developed so that an individual could deposit money into such an account without being required to pay taxes on those funds until they are withdrawn.

Private long term health insurance. It is thought by some that private health insurers should be able to provide certain long term care benefits, either as part of their health insurance policies which are sold to employers or as a distinct insurance package sold to individuals. It is projected that 47 percent of the people between the ages of 67 and 69 who have assets of at least $3,000 would buy such insurance if it cost ten percent or less of their annual income. This could reduce Medicaid costs by as much as 23 percent, or $9 billion, over a 35-year period. Using a more conservative assumption that people would purchase such insurance only if the premiums cost less than five percent of their annual income, it is projected that 21 percent of the same group would buy it, producing an approximately eight percent savings for Medicaid over the same 35-year period. In addition to saving approximately a quarter of the Medicaid budget for nursing home care, private long term care insurance could help curtail the rate of conversion from private pay patients to Medicaid patients and help individuals plan for their retirement health care needs.

Among the advantages identified in the development of private long term insurance are the following: 1) insurance provides financial support for the purchase of quality care; 2) insurance enhances the opportunity for consumer choice; 3) insurance preserves the dignity of elderly persons by giving them the opportunity to prudently plan for their potential long term health care needs; 4) insurance reduces federal and state exposure for the costs of future long term health care services; 5) insurance can help reduce reliance upon public programs as the source of payment for such services; and 6) insurance assures market competition and induces the expansion of diversified service delivery.

Other alternatives in the private sector. While publicly financed alternatives seem to be facing federal and state fiscal restraints, private sector alternatives seem to be attracting increased attention because of the improved economic status of some of the elderly. Recent economic reports show that the median real annual income of the elderly has more than doubled since 1950 to more than $21,420 (before taxes) for families 65 years of age and over. Among the options that could bring more private dollars into long term care are financing arrangements designed to free up income that many elderly have tied up in their homes, such as a "reverse annuity mortgage" in which an individual retains title to a house but draws on the equity for monthly cash. Another approach is "life care communities" where elderly people pay an initial lump sum and monthly fees to live in a private community that offers medical, nursing, and social services.

Committee Activities

The committee received testimony from the Department of Social Services concerning the operation of the home and community based program and the department's role in reimbursing nursing homes for elderly Medicaid clients. Also, testimony was received from the Department of Health concerning the department's role in licensing and regulating nursing homes. The Colorado Association of Homes and Services for the Aging and the Colorado Health Care Association provided testimony regarding various issues in the operation of nursing homes and the provision of services to the elderly. A representative from the American Health Care Association addressed the committee on the subject of private long term care insurance. Finally, the committee received testimony from the Commissioner of Insurance regarding the ability to provide long term care insurance in Colorado.

Committee Recommendations

The committee was particularly interested in whether legislation is necessary to remove any statutory barriers that might prevent the expansion of private long term care insurance and whether legislation is necessary to encourage the private market to be more aggressive in providing private long term care insurance. The committee was informed that there are thirteen companies in Colorado which are licensed to offer long term care insurance and that there is access to the product for those who wish to purchase such coverage. In addition, the committee determined that there are no statutory prohibitions to the marketing of long term care insurance in Colorado and that legislation is not necessary at this time. As a result, the committee did not recommend any bills on this subject. The committee does recommend a bill establishing individual medical accounts.

Concerning Deductions From Resident Individual's Colorado Adjusted Gross Incomes For Contributions Made to Individual Medical Accounts -- Bill 23. The committee recommends Bill 23 which will create the "Individual Medical Account Act of 1986". The bill allows a specified deduction per taxable year (not to exceed $2,000 per account holder) from Colorado adjusted gross income for contributions to an individual medical account (IMA). The account, which is established as a trust and placed with a trustee, is to pay the medical and dental expenses of the account holder after a one hundred dollar deductible is paid. The trustee is to purchase major medical coverage for each account holder to cover medical expenses in excess of ten thousand dollars annually.

The account holder is not eligible to purchase other health insurance coverage after the medical account has accumulated $5,000. The bill imposes a tax penalty for withdrawals from the account before the account holder is 59 and one-half years of age. The individual medical account becomes part of the account holder's estate upon his death.

OTHER TOPICS CONSIDERED

Despite the committee's focus on three particular aspects of the health care cost problem (medical indigency in Colorado, establishment of a health insurance risk pool, and long term care), numerous other aspects of the problems of health care costs were discussed. Medical malpractice, the certificate of public necessity law, the Medicaid program, the old age pension program, limitations on a physician's right to practice medicine, and testing for rubella prior to application for a marriage license were discussed by the membership and various bills were recommended on these subjects.

Medical Malpractice

The Medical Malpractice System

Ten years after a crisis in medical malpractice insurance availability, medical malpractice is once again in a prominent position in state legislative consideration. Although the malpractice crisis in 1975 inspired reform legislation across the states, the focus was on insurance availability. Currently, medical care providers and malpractice insurers are concerned with the growing number of malpractice lawsuits and the increasingly large damage awards and settlements.

Medical malpractice is considered negligent care by a health care provider that causes injury to the patient. Regardless of severity, a bad treatment result is not necessarily medical malpractice unless the provider was at fault. Actions for malpractice are brought by injured parties who believe they are the victims of such medical negligence. Individuals or companies involved in the direct and indirect provision of patient care can be sued for medical malpractice; this can include doctors, other health care personnel, hospitals, and pharmaceutical and equipment companies. The two major goals of malpractice law are to provide compensation to victims and to deter substandard care through the threat of legal action.

The medical malpractice system involves both the liability insurance industry and the formal legal process. In order to be compensated for an injury arising from medical negligence, the injured party must establish a breach of the legal standard of care, compensable injury to the patient, and a causal connection between the breach of care and the injury. Medical malpractice suits are generally resolved through the tort system. Legal doctine and institutions determine which claims will be brought, whether settlements will be made, and the level of payment awarded even in situations where full recourse to the legal system is unnecessary.

A 1982 Rand Corporation study indicates that one-half of all malpractice claims are dropped without payment and that two-thirds of

those are dropped before a lawsuit is filed. The same study also showed that, between 1975 and 1976, out of 6,000 malpractice claims reviewed nationally, less than ten percent were tried all the way to a verdict. Seventy-five percent of the ten percent of claims resolved by a jury verdict favored the defendants (providers).

Lawsuits are most commonly filed because of bad treatment results, injuries resulting from treatment, misdiagnosis, failure to treat, or improper treatment. Providers are also sued by patients for failure to obtain "informed consent" -- for withholding all of the available information concerning the planned procedure. Malpractice attorneys are usually paid a percentage of the settlement or award as a fee (contingent fee), allowing the patient to pursue malpractice claims without concern for paying an attorney in advance.

Health care providers purchase malpractice insurance in order to protect themselves from malpractice claims. Premium costs are determined by geographic area and, in the case of physicians, by their medical specialty. Surgeons, obstetricians, and anesthesiologists are more likely to pay high premiums. The malpractice insurance industry is moving towards a claims-made system, under which insurers are contractually responsible for claims filed only during the coverage year. Previously, most malpractice insurance was written on an occurrence basis whereby the insurance company was financially responsible for claims resulting from treatment rendered during the coverage period regardless of when the claim was filed. This type of insurance underwriting led to long periods of exposure to unfiled malpractice claims, making premium and reserve levels difficult to determine.

Trends in Medical Malpractice

In recent years, the number of malpractice claims, the size of awards, and the cost of malpractice insurance have increased steadily. According to the National Conference of State Legislatures, the frequency of malpractice claims began increasing in 1979. Physician-owned malpractice insurers saw an increase in claim frequency from 12.17 cases per 100 physicians in 1979 to 20.3 cases per 100 physicians in 1983. The St. Paul Fire and Marine Insurance Company (the nation's largest malpractice insurer) saw hospital claims rise from 1.75 per 100 beds in 1979 to 3.0 per 100 beds in 1983.

Malpractice awards have been increasing even more dramatically in amount. Again, according to the National Conference of State Legislatures, the St. Paul Company has seen its average loss per hospital claim, including allocated loss expense, grow from less than $5,000 in 1975 to more than $12,000 in 1983. In 1984, American Medical Association data compiled from physician-owned insurers shows the average paid loss increasing from approximately $20,000 in 1979 to $72,000 in 1983. In addition, the average malpractice jury award grew from $166,000 in 1974 to $888,000 in 1983, a fivefold increase, according to Jury Verdict Research.

Not only have the number of malpractice claims and the amount of malpractice awards increased, the average malpractice premium costs have also been rising. Although, according to the American Medical Association, average premiums grew only 51 percent between 1976 and 1983 and represented 4.4 percent of a physician's gross income in 1976 and 3.7 percent in 1983, recent insurance rates have risen markedly. Many physician-owned insurers increased rates from ten to 39 percent in 1984. The average rate for obstetricians went from $8,300 in 1978 to $14,100 in 1983, while surgeons saw their average rates increase from $7,187 to $10,900.

The growth in the number of claims, the size of awards, and the costs of malpractice insurance can be attributed to many factors. These include the following:

-- rapid rises in health care costs reflected in damage awards;

-- rising expectations by patients and jurors of medical treatment success;

-- changes in medical technology that have increased the use of dangerous and invasive treatments and diagnostic procedures;

-- increased incidence of claims for adverse birth-related outcomes, which may entail supporting a victim throughout his life;

-- impared doctor/patient communication;

-- increased willingness to sue in general; and

-- increased sophistication of malpractice attorneys.

Committee Recommendations

Provider groups and malpractice insurers are looking to state legislatures for changes to the malpractice system. Alternative approaches to the malpractice issue, such as the use of pretrial screening panels, arbitration, caps on damage awards, and informed consent, were discussed by the committee prior to its recommendation of two bills concerning malpractice.

Concerning Informed Consent to Medical Procedures -- Bill 24. The doctrine of informed consent requires physicians to inform patients of the risks of treatment procedures, and of alternative treatments and their risks, as well as to obtain the patient's consent to the agreed-upon procedure. A physician may be liable for adverse results if he does not obtain the patient's informed consent. A physician need not inform a patient of commonly known risks, unforeseeable risks, or medical emergency procedure risks. Because of the amorphous nature of the informed consent doctrine, it is subject to varying applications. Bill 24 is an attempt to create a clear standard of informed consent for Colorado.

Bill 24 creates the Colorado Committee on Informed Consent which is to assist the State Board of Medical Examiners in adopting a doctrine of informed consent. The purpose of the doctrine is to specify what information is sufficient for physicians to provide to their patients relating to the likely consequences of proposed medical procedures. The committee is composed of a licensed physician, a licensed attorney, and a third member recommended by the first two members.

Pursuant to Bill 24, which recreates and reenacts part 3, article 20, title 13, C.R.S., a physician may provide a patient with a written statement of informed consent which is in compliance with the doctrine adopted by the board with the committee's assistance. When any patient signs such a written statement regarding a medical procedure, that patient has no cause of action for lack of informed consent against a physician who also signs the statement. Bill 24 does not bar an action against a physician for negligent performance of the procedure in question.

Concerning a Pretrial Panel Requirement for Medical Malpractice Claims -- Bill 25. Pretrial screening panels, which are currently operating in 23 states according to the National Conference on State Legislatures, may speed the resolution of disputes and limit litigation costs. In most states with panels, the panel must review claims before the action can be tried in court. Panels are generally composed of members of both the legal and medical professions. Courts in some states have invalidated pretrial panels on the grounds they unduly impeded access to courts and a jury trial, were arbitrary and capricious in their operation, or violated equal protection guarantees by treating medical malpractice differently from other negligence actions.

Proponents of panels argue that they not only will weed out less meritorious claims and encourage out-of-court settlements but will also lessen the cost of litigation. Opponents believe that panels may increase costs by requiring an additional level of litigation, that provider representation on panels can introduce a bias against claimants, and that panels whose decisions are admissible in court should not be conducted under different evidentiary and procedural rules.

Bill 25 establishes the structure of and the procedures to be followed by pretrial panels created to screen medical malpractice claims. The bill requires all personal injury and wrongful death claims for damages arising out of the provision of or failure to provide health care to receive pretrial consideration from a panel appointed by the presiding judge. Each panel is composed of: 1) a member licensed to practice law (chairman); 2) a member who is a health care provider; and 3) a member who is not a lawyer or a health care provider and who is selected by the other panel members.

The bill provides for the implementation, administration, and conduct of pretrial panel proceedings. The Colorado Supreme Court is

to promulgate rules and regulations as necessary to implement the bill. In addition, proceedings are to be confidential and informal; evidence of the proceedings and their results, opinions, and findings are not admissible as evidence in a subsequent trial. Therefore, the rules of evidence are not applicable in pretrial panel proceedings and no record of the proceedings is necessary.

In requiring medical malpractice claims to be screened prior to trial, the bill provides that the panel determine the merit of each claim and, if meritorious, render an assessment of a fair and reasonable amount to settle each claim. If either party does not accept a settlement claim in the amount determined by the panel, and the case subsequently is brought to trial, the party bringing or forcing the action must "do" better than the settlement amount by ten percent. If the final judgment amount does not justify the costs of going to trial, either the party who brought or the party who forced the action is required to pay the other party's reasonable costs and attorney fees.

Bill 25 also authorizes the Judicial Department to charge fees to cover all the costs of pretrial panel proceedings. Such fees are to be maintained and credited to the medical malpractice panel cash fund, which is created by the bill.

Certificate of Public Necessity

Committee Recommendations

Concerning the Repeal of the "Colorado Certificate of Public Necessity Act" -- Bill 26. The committee recommends the enactment of Bill 26 which will repeal the "Colorado Certificate of Public Necessity Act" enacted in 1973. Rapid transformation and continuing developments in the competitive health care market over the past number of years have created uncertainty about the need for continued public regulation of the health industry's investment decisions and had lead to the recommendation to discontinue such regulation. Some of the major factors contributing to a change in the health care delivery environment are summarized below.

-- In 1983, reforms in Medicare established a prospective payment system to reimburse hospitals according to predetermined prices based on a patient's diagnosis. The prospective payment system has changed hospital behavior to a more businesslike operation. Under the fee-for-service system in which hospitals and doctors were reimbursed for all of their costs, including the cost of capital to build and buy equipment, unprecedented growth in the number of hospitals and the delivery of health care was fostered, regardless of cost.

-- The new Medicare reimbursement system has been useful in reducing patients' average length of stay from 7.2 days in 1982 to 6.7

days in 1984 for all patients, and from 10.1 days to 8.9 days for Medicare patients over the age of 65. In Colorado, the average length of stay has fallen from 6.2 days in 1982 to 5.6 days in 1984 for all patients, and from 9.1 days to 7.6 days for patients over the age of 65.

-- Hospital admission rates nationwide fell from 37.9 million in 1982 to 36.3 million in 1984. In Colorado, admissions fell from 485,018 in 1981 to 381,303 in 1984. Additionally, state admissions in 1984 decreased 6.4 percent for the total population, and 7.2 percent for people 65 years of age and older. Nationwide occupancy rates fell from 75.8 percent in 1981 to 66.6 percent in 1982. Occupancy rates in Colorado hospitals averaged 54.5 percent in 1984 compared to 62.7 percent in 1983.

-- Other factors have put pressure on hospitals to cut costs such as the growth of HMOs which can reduce a hospital's business because the HMO has incentives to keep enrollees' costs down by avoiding hospital stays. In addition, the setting of prices for a defined unit of service has allowed consumers to compare hospitals and to shop among them.

-- In order to help offset declining inpatient revenues, and to attract more patients, hospitals are expanding in numerous ways, such as setting up specialty clinics (sports medicine, women's health or fitness classes, drug and alcohol abuse), acquiring related businesses, developing alternative health care delivery systems such as freestanding emergency clinics, entering into discount or flat-fee arrangement such as PPOs and HMOs, getting into the nursing home and home health care business, and establishing one-day surgery centers. The four largest multi-state for-profit hospital chains have acquired their own insurance companies so that each chain can now offer its own insured or prepaid plan.

-- At the same time that hospitals are branching out, they are also banding together with other hospitals in the search for better economies and better access to capital so they can be more attractive to large group purchasers by providing full-service health care networks.

-- It has been predicted that the competition between the various health plans will drive ten percent of the nation's hospitals into bankruptcy by 1990, causing 200,000 acute care beds to be closed down or converted to other uses. If the competition does indeed eliminate some facilities and services, it is argued by some that many of them were duplicative to begin with and new, more efficient systems will be found to deliver needed services. This may be a useful reduction of excess capacity.

Many hospitals are internally evaluating their operational decisions in an effort to position themselves in the changing health care market. These decisions may involve narrowing the scope of

inpatient services, expanding and diversifying outpatient and community services, and more traditional considerations such as whether and when to renovate or acquire expensive new equipment. Utilization rates may well continue to decline. Hospital decisions to specialize within the range of inpatient services and to diversify beyond inpatient care are calculated on their perceptions of market demand. At risk is a future sufficient patient base.

The federal government has indicated that it expects to change the capital-related reimbursement mechanism in Medicare in 1986. Furthermore, more third party payers are moving to prospectively determined or negotiated rates. All these factors serve as constraints to imprudent capital expenditures and it is believed by many that hospitals will limit their capital purchases voluntarily. Thus, the committee concludes that the time has come to repeal the certificate of public necessity law.

Physician Employment

Current Statutory Provisions

Existing law prohibits the employment of physicians by any nonprofessional corporation or by any person not licensed as a physician, with limited exceptions. Existing law also prohibits the practice of medicine by corporations and other legal entities (section 12-36-117, C.R.S.). Over the past few years many changes have taken place in the delivery of health care and the manner in which health care services are provided and paid for. These changes have required health care providers to organize and deliver their services in the most cost-effective manner possible and to develop new competitive alternatives to traditional health service patterns.

Current law may encumber the development of new forms of health care organization and delivery. In addition, the current law creates uncertainties relating to the existing contractual relationships between physicians and hospitals or other health care facilities. The current law places barriers to those health care facilities and physicians who may wish to enter into contractual arrangements to offer innovative forms of health services. The existing law may place some hospitals and physicians at a competitive disadvantage with other forms of health care organizations which are authorized to enter into various types of contracts with institutional and professional providers of health care.

Committee Recommendations

Concerning the Freedom of Physicians to Practice Medicine, and in Relation Thereto, Expanding the Rights of Physicians to Work for Employers and Treat Patients -- Bill 27. In order to allow for the ability of physicians and hospitals to enter into mutually acceptable

contractual arrangements for the delivery of health services, the committee recommends the adoption of Bill 27. This bill will allow for a more complete response to the emerging competitive health care and financing system for all providers. Bill 27 amends the definition of "unprofessional conduct" in the Colorado Medical Practice Act to permit licensed physicians to be employed by certain entities other than licensed physicians. Specifically, the bill permits physicians to: 1) be employed by hospitals, hospital-owned corporations and health maintenance organizations; 2) work for partnerships or associations where a majority of the partners or associates hold a license to practice medicine; and 3) examine and treat the dependents of persons, partnerships, associations, or corporations employing such physicians.

Marriage License Requirements

Committee Recommendations

Concerning Requirements for the Issuance of a Marriage License -- Bill 28. The committee recommends Bill 28 which repeals the provision of Colorado law that requires a female applicant for a marriage license to present a certificate stating that she has received a serological test for rubella immunity and Rh type (sections 14-2-106 (1) (a) (III) and (2), C.R.S. The Department of Health no longer considers this test necessary as there have been no cases of congenital Rubella syndrom found in infants born in Colorado since 1975. In addition, Rh type testing is a usual part of prenatal care and generally occurs during the first trimester of pregnancy.

Old Age Pension-B Program

Background

In November, 1936, the voters of Colorado approved Article XXIV of the Colorado Constitution. This article created the Old Age Pension Fund and set forth basic guidelines concerning the use and operation of the fund. Colorado statutes implementing the constitutional article and providing for administration of the Old Age Pension Fund (OAPF) were enacted in 1937 -- see sections 26-2-111 (2) and 26-2-112 through 26-2-117, C.R.S.

Article XXIV was amended in 1956 to add a section creating the OAP Stabilization Fund and the OAP Health and Medical Care Fund. In 1978, the statute was amended to provide for adult foster care and home care awards as a benefit under OAP. In 1979, a provision was added to the statute authorizing payments for heat and fuel expenses during the winter months of December through April.

Revenue Sources

The constitution and statutes provide that the following monies must be allocated to the OAPF:

-- 85 percent of all excise taxes;
-- 85 percent of retail license fees;
-- 85 percent of liquor license fees;
-- any federal grants for old age assistance;
-- ten percent additional amount of incorporation fees; and
-- ten percent additional amount of inheritance taxes.

In 1984, these revenue sources generated $655.1 million for the OAPF. Any monies left in the OAPF after paying awards are transferred to the Old Age Stabilization Fund. The stabilization fund is required to be maintained at $5 million. Monies in the stabilization fund are used solely to stabilize payments of old age pension awards. After satisfying the OAPF and stabilization fund requirements, the remaining funds are transferred to the Old Age Pension Health and Medical Care Fund. Monies in this fund, up to $10 million annually, are used to provide health and medical care to persons who qualify for old age pensions (except those in tuberculosis or mental institutions). All remaining monies flow into the general fund. From the $655.1 million of revenue generated for the OAPF by the various sources in 1984, $609.6 million was transferred to the general fund.

Eligibility Requirements

The OAP program provides financial assistance to those persons age 60 years and over who have insufficient resources to meet their needs. Persons who have reached the age of 60 are eligible for OAP assistance if the following conditions exist:

-- they are a resident of Colorado;

-- they have insufficient income or other resources to meet their needs, as determined by the Department of Social Services rules and regulations;

-- they have not made a voluntary assignment or transfer of property without "fair and valuable consideration" for the purpose of becoming eligible for public assistance at any time within five years prior to filing an application for assistance; and

-- they are not an inmate of a penal institution (residents of other institutions maintained by the state or a local government are eligible).

The income and property of an applicant's spouse is considered in determining eligibility. However, a person who is otherwise eligible, but has relatives financially able to contribute support, cannot be denied an old age pension. If a person's total income exceeds the

total maximum award, that person is not eligible for any assistance.

Colorado's OAP program is unique in that persons are eligible at the age of 60. Pensioners between the ages of 60 and 65 are referred to as recipients of OAP-B while persons over the age of 65 are recipients of OAP-A. The OAP-A program is funded by both the state and federal governments (through the federal Medicaid match) while the OAP-B program is funded only by the state. Prior to 1979, applicants for the OAP-B program were required to live in Colorado for 35 continuous years immediately preceding the date of application. However, the Colorado Supreme Court held, in Jeffrey v. Colorado State Department of Social Services, 599 P.2d 874 (1979), that the state old age pension statute which established two classes of needy citizens between the ages of 60 and 65 -- the only distinguishing characteristic being the length of continuous residence in Colorado -- was unconstitutional and denied equal protection of the law. Since 1979, all residents of Colorado over the age of 60 are eligible for application to the OAP-B program.

Benefits and Awards

There are six types of awards or benefits available to qualified OAP recipients. The basic minimum award is set in the constitution and the statutes at $100 monthly, but the amount of net income from any source that a person may have must first be deducted from the monthly pension the person would otherwise receive. Also, the basic minimum award is adjusted upwards by the Department of Social Services twice a year to reflect increased costs of living. The basic minimum award was set at $364 in July of 1984, and $372 in January of 1985, and is projected to increase to $399 in July of 1986.

In 1979, adult foster care was added as a benefit and involves services provided in certified nonmedical facilities. This award may also be adjusted by the department. The maximum award is currently set at $319 a month and is projected to increase to $332 in 1986. Home care was also added in 1979 and involves care provided in the recipient's own home. This award may also be adjusted by the department and the maximum is currently set at $172 per month. The maximum amount is projected to increase to $179 per month in 1986.

Since 1979, OAP recipients are also eligible for $32 each month for December through April per household for winter utilities. This award is reduced to $16 per month for a married couple if both are qualified to receive old age pension. Funeral and burial expenses are awarded at the statutory rate of $500 for funeral expenses and $200 for burial expenses if the estate of the deceased is insufficient to pay such expenses and the persons legally responsible for the support of the deceased are unable to pay them.

OAP-A and OAP-B clients are also eligible for medical benefits. OAP-A clients who are over 65 years of age are for the most part eligible for Medicaid benefits under Title XIX of the federal Social

Security Act. OAP-B clients between the ages of 60 and 65, unless they qualify under the disabled categories for Medicaid, are not eligible for Medicaid under Title XIX. OAP-A Medicaid clients are entitled by law (state and federal) to the same benefit package as all other Medicaid clients. The OAP-B clients receive the same package of benefits, including long term care, as the OAP-A clients, except that these benefits are provided with state-only dollars through the Old Age Pension Health and Medical Fund.

Number of Clients and Expenditures for Old Age Pension Benefits

In 1981, there were 23,129 clients of OAP who met the eligibility requirements for the basic minimum award. The expenditures for such an award were $21,930,797. For fiscal year 1982-83, there was an average monthly OAP caseload of 23,442. OAP-A recipients accounted for 19,196 cases, while OAP-B recipients accounted for 4,246 cases. For 1984, the average monthly caseload was 24,395 (19,735 -- OAP-A, 4,660 -- OAP-B). It is projected that there will be 24,615 clients in 1986 which will result in a projected expenditure of $30,128,760. In 1981, there were 39 clients of OAP who received adult foster care awards amounting to an expenditure of $42,588. This category of award under OAP is projected to increase to 237 clients at an expenditure of $384,452 in 1986. In 1981, there were 561 OAP clients eligible for home care at an expenditure of $1,522,619. The client caseload is projected to increase to 3,118 in 1986 at a projected expenditure of $8,274,548. In 1981, expenditures for funeral and burial awards was $147,335. It is projected that the expenditures in 1986 will approximate $165,000. In 1981, there were 22,912 OAP clients who qualified for winter utilities reimbursement at an expenditure of $3,329,250. It is projected that in 1986 there will be 23,541 OAP clients eligible for such assistance at an expenditure of $3,438,163.

The average monthly number of recipients for the OAP basic minimum award has remained relatively constant since 1981. The 1985 total is 4.9 percent higher than the 1981 total. The number of home care recipients has increased almost five times, while recipients of adult foster care have increased almost four times. In 1981, expenditures for the five categories of assistance outlined above pursuant to the OAP program was $26,972,559. In 1986, it is projected that the expenditures for the five categories of OAP assistance will increase to $42,390,123. For a total OAPF expenditure in those years the $10 million allocated to the Old Age Pension Health and Medical Care Fund must be added.

Total client caseload and total annual expenditures for OAP programs have increased steadily over the years. In 1985, expenditures were projected to be 43.2 percent higher than in 1981 and the figure for 1987 is projected to be 67.3 percent higher. Most of this increase is accounted for by the growth of the basic minimum payment and the home care award ($14,949,892 of the total $15,417,564 increase from 1981 projected into the year 1986).

During fiscal year 1982-83, in excess of $104 million was spent on health and medical expenses for OAP recipients. This figure includes both state and federal funds through the Medicaid match. The department estimate for 1983-84 is approximately $107.9 million. Approximately $100.9 million was spent on medical services for OAP-A recipients, while $7 million was spent on OAP-B recipients. Of the $7.7 million spent on OAP-B recipients, approximately $4,644,000 was from state-only funds.

Old Age Pension Health and Medical Fund

The OAP Health and Medical Fund ($10 million annually) first pays the medical expenses of those recipients who are not Title XIX Medicaid eligible, Any monies available after payment of OAP state-only claims are then applied to the Medicaid program in order to match federal funds. Because the size of the OAP-B population has grown, and the level of expense from the fund for OAP-B clients has also grown, the impact on the Medicaid budget has been significant. In other words, the amount of money from the $10 million fund required to make the "state only" payment has been increasing, leaving less available to be matched with federal Medicaid funds. For example, in 1985, $8.8 million of the $10 million fund was needed to pay for state-only OAP-A and OAP-B medical expenses, as compared with $6.7 million in 1983 and $3.6 million in 1982. In 1982, a total of $12.8 million was derived from matching federal Medicaid funds, in 1983, $6.6 million was available, and in 1984 only $2.4 million was available with federal matching funds. Thus, there are fewer state general fund dollars available out of the OAP Health and Medical Fund to match other federal Medicaid dollars. The overall impact indicated by this relationship is apparent through the affect it has on the general fund Medicaid appropriation.

OAP-B Profile

Information gathered from the Department of Social Services data file for OAP-B clients and from a mass redetermination questionnaire of OAP recipients indicates the following:

	Total Data File	Response to Questionnaire
Caseload/respondents	4,780	3,367
Male	27.8%	26.4%
Female	72.2%	73.6%

Primary Reason For Applying for OAP

Total Answers		3,183
Retired		22.5%
Homemaker	1/	11.9%
Disabled	2/	56.6%
Unemployed		12.2%
Other		11.4%

Other Assistance

-- 35.9 percent of all respondents (1,198) indicated receipt of other assistance as follows:

AFDC	544	45.4 percent
AND	737	61.5 percent
AB	16	1.3 percent
IRA	54	4.5 percent

-- These percents total 112.7 percent, therefore, 12.7 percent of the recipients received two or more types of assistance prior to OAP participation.

Other Facts

-- 93.8 percent were citizens and 6.2 percent were not. Of the 207 noncitizens, 143 indicated they were sponsored when they immigrated.

-- 30.8 percent had a sixth grade or less education, 30.8 percent had a seventh through ninth grade education, 32.1 percent had a tenth through twelfth grade education, and 6.2 percent had an education beyond the twelfth grade.

-- 55.3 percent have resided in Colorado for more than 35 years. 15.3 percent have resided in Colroado for less than five years.

-- 74 percent have children in Colorado and 26 percent do not have children in Colorado.

1/ Homemaker without job experience

2/ The medical eligibility file lists 2,271 OAP-B recipients as disabled based on SSI criteria. This is 45.2 percent of the OAP-B caseload. 56.6 percent of the clients consider themselves disabled exceeding the SSI percentage by 11.4 percent.

-- 218 clients receive home care, 18 receive adult foster care, and 4,612 receive winter utilities.

-- 36.2 percent receive SSI ($202.97 average), 45.7 percent receive OASDI ($248.66 average), 1.85 percent have earned income ($131.56 average), 7.7 percent receive income from spouse ($127.00 average), and 4.73 percent are in nursing homes.

~~Committee Recommendations~~

Submitting to the Registered Electors of the State of Colorado an Amendment to Section 3 of Article XXIV of the Constitution of the State of Colorado, Changing the Minimum Age of Eligibility for Public Assistance in the Form of Old Age Pensions to Age Sixty-Five -- Bill 29. The committee recommends Bill 29, a concurrent resolution, which eliminates the Old Age Pension-B program by changing the minimum age of eligibility for state public assistance in the form of pensions from age sixty to age sixty-five. The issue will be submitted to the state's electors at the next general election (1986) to become effective on and after January 1, 1987. The amendment does not affect those persons already participating in the OAP-B program.

~~Medicaid Changes~~

~~Committee Recommendations~~

Concerning Vender Participation in Prepaid Capitated Programs Under the "Colorado Medical Assistance Act" -- Bill 30. The committee recommends Bill 30 which authorizes the Department of Social Services to negotiate contracts with vendors to provide Medicaid services based on a fixed rate of reimbursement per recipient. Currently, most Medicaid services are reimbursed on a fee-for-service basis, although providers only receive a percentage of their costs. These contracts may only be awarded after a determination by the executive director of the department that the contract will reduce the costs of providing Medicaid benefits. In order to implement the provisions of Bill 30, the soliciting and awarding of bids by the department is exempted from the provisions of the Procurement Code.

The provisions of the bill are not applicable to prescription drug providers. In addition, the department is to make good faith efforts to obtain a waiver of the "freedom of choice" requirements of Title XIX from the federal Department of Health and Human Services in order to implement Bill 30.

Concerning the Consideration of the Voluntary Assignment or Transfer of Property in Determining Eligibility for Public Assistance -- Bill 31. Current law provides, among other requirements, that a person may be eligible for public assistance (including medical assistance) if he has not made a voluntary assignment or transfer of

property without fair and valuable consideration for the purpose of rendering himself eligible for public assistance at any time within five years immediately prior to seeking such public assistance. However, the law additionally provides that such a transfer or assignment of real property used as a residence may be completed by the applicant if "the primary purpose of the transfer or assignment is not to acquire moneys or profit but is for some other legitimate reason such as estate planning". The purpose of Bill 31 is to repeal this exception to the general prohibition on the assignment or transfer of property in determining eligibility for public assistance. Thus, no person would be eligible for public assistance if they had assigned or transferred their property without fair consideration. The committee believed that this exception was no longer necessary for two reasons: 1) the state of Colorado does not collect an inheritence tax; and 2) pursuant to federal law, estates valued under $474,000 are not taxed.

BILL 17

A BILL FOR AN ACT

CONCERNING THE PROGRAM FOR THE PROVISION OF HEALTH CARE SERVICES FOR THE MEDICALLY INDIGENT.

Bill Summary

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

Makes various changes in the "Medically Indigent Health Care Act", including, but not limited to, the following:

Declares that the purpose of the program for the medically indigent (program) is to aid local governments and local hospitals in carrying out their traditional responsibility to provide medical services to the medically indigent population. Defines medically indigent person. Adds free-standing ambulatory surgical and emergency facilities to the definition of provider. Removes associated physicians from the definition of provider. Explicitly requires the university of Colorado university hospital (health sciences center) to promulgate rules in accordance with the "State Administrative Procedure Act" as necessary to implement the program. Requires that such rules require the use and enforcement of an ability-to-pay scale and a copayment schedule.

Authorizes the health sciences center, acting as administrator of the program, to reimburse itself for acting as a provider in the program, at a rate not exceeding that given to other providers. Authorizes the health sciences center to solicit competitive bids from providers seeking to participate in the program. Removes the requirement that Denver health and hospitals be designated as the primary provider of medical services to the medically indigent for the city and county of Denver. Removes the requirement that the health sciences center be designated as the primary provider

of medical services to the medically indigent for the Denver standard metropolitan statistical area. Authorizes the health sciences center to contract with additional hospitals when necessary for the provision of complex care in the program. Requires that each contract with a provider provide for the reimbursement of a percentage of the average cost of each medical services provided. Based on available appropriations, requires the health sciences center to periodically adjust the percentage.

Requires that the general appropriation act provide separate line items for: Education and research programs funded by the state at Denver health and hospitals and the health sciences center; and the reimbursement of providers under the program.

Provides that a single determination of eligibility in the program shall be valid for no longer than one year from the date of such determination. Authorizes the health sciences center to obtain records pertaining to the eligibility of an applicant to the program from any wage and employment data available from the department of labor and employment. Provides that, by signing an application, a medically indigent person specifically waives any right to file a civil action for damages arising out of the good faith acts or omissions of providers rendering medical services to such person pursuant to the program.

Prohibits the health sciences center from reimbursing inpatient services if they can be performed less expensively in the outpatient setting. Specifies the types of medical services that are and are not eligible for reimbursement pursuant to the program. Requires that the program be the payor of last resort and that the program not duplicate county or regional programs funded by the department of health.

Abolishes the joint review committee for the medically indigent and the technical advisory committee on the medically indigent.

Repeals a provision which would have repealed the program in 1990, thereby providing for the indefinite existence of the program.

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

SECTION 1. 26-15-101, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended to read:

26-15-101. Short title. This article shall be known and may be cited as the ~~"Reform Act for the Provision of Health Care for the Medically Indigent"~~ "MEDICALLY INDIGENT HEALTH CARE ACT".

SECTION 2. 26-15-102 (1) (a), Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended, and the said 26-15-102 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

26-15-102. Legislative declaration. (1) (a) The state has insufficient resources to pay for all medical services for persons who are indigent and must therefore allocate available resources THROUGHOUT THE STATE in a manner which will provide treatment of those conditions constituting the most serious threats to the health of such medically indigent persons, as well as increase access to primary medical care to prevent deterioration of the health conditions among medically indigent people; and

(3) The general assembly further determines, finds, and declares that traditionally the responsibility for providing medical services to the medically indigent has been a responsibility of local governments and local hospitals and that this responsibility has become insupportable. Therefore, the purpose of this article is to aid local governments and local hospitals in carrying out their responsibility to provide medical services to the medically indigent.

SECTION 3. 26-15-103 (1) and (4), Colorado Revised Statutes, 1982 Repl. Vol., as amended, are amended, and the said 26-15-103 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

26-15-103. Definitions. (1) "Emergency care" means treatment for ACUTE, SEVERE conditions ~~of an acute, severe~~

nature which are life, limb, or disability threats requiring immediate (minutes to hours) attention, where any delay in treatment would, in the judgment of the responsible physician, be definitely harmful and would threaten life or loss of function of a patient or viable fetus.

(2.5) "Medically indigent" means a person too impoverished to meet his medical expenses and who has an income level equal to or less than one hundred fifty percent of the current federal poverty level, as promulgated by the United States department of health and human services, after deducting incurred medical bills and insurance premiums. A person's assets shall be included in the determination of such income level to the extent that they would be included in the determination of that person's eligibility for medical benefits under the "Colorado Medical Assistance Act", article 4 of this title. A provider providing medical services to a person meeting this definition is not necessarily entitled to reimbursement for such services under this article. Any such reimbursement shall be pursuant to the terms and conditions of this article.

(4) "Provider" means any general hospital, community clinic, or maternity hospital, FREE-STANDING AMBULATORY SURGICAL FACILITY, OR FREE-STANDING EMERGENCY FACILITY licensed or certified by the department of health pursuant to section 25-1-107 (1) (l) (I) or (1) (l) (II), C.R.S., any health maintenance organization issued a certificate of authority pursuant to section 10-17-104, C.R.S., and the

health sciences center when acting pursuant to section 26-15-106 ~~(5)-(a)-or~~ (5) (b) OR (6) (a). A home health agency may also serve as a provider of community maternity services. ~~For--the--purposes--of--the---program;---"provider"---includes associated-physicians.~~

SECTION 4. 26-15-103 (2) and (3), Colorado Revised Statutes, 1982 Repl. Vol., as amended, are REPEALED AND REENACTED, WITH AMENDMENTS, to read:

26-15-103. Definitions. (2) "Health sciences center" means the university of Colorado university hospital provided for in part 1 of article 21 of title 23, C.R.S.

(3) "Program" means the program for the medically indigent established by section 26-15-104.

SECTION 5. 26-15-104, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended to read:

26-15-104. Program for the medically indigent established. A program for the medically indigent is hereby established, ~~to--commence--July--1,--1983,~~ which shall be administered by the health sciences center, to provide payment to providers for the provision of medical services to eligible persons who are medically indigent. The health sciences center ~~may~~ SHALL promulgate such rules and regulations as are necessary for the implementation of this article in accordance with article 4 of title 24, C.R.S.

SECTION 6. The introductory portion to 26-15-105 (1) and 26-15-105 (1) (d) and (1) (l), Colorado Revised Statutes, 1982 Repl. Vol., as amended, are amended to read:

26-15-105. Report concerning the program. (1) The health sciences center ~~in--cooperation--with--the-technical advisory-committee--created--pursuant--to--section--26-15-108;~~ shall prepare an annual report to the ~~joint-review-committee created--pursuant--to--section--26-15-107~~ GENERAL ASSEMBLY concerning the medically indigent program. The report shall be prepared following consultation with contract providers in the program, state department personnel, and other agencies, organizations, or individuals as it deems appropriate in order to obtain comprehensive and objective information about the program. The report shall contain a plan for a delivery system to provide medical services to medically indigent persons of Colorado in a manner which assures appropriateness of care, prudent utilization of state resources, and accountability to the general assembly. The health sciences center shall submit the report to the general assembly no later than February 1 of each year. The report shall include recommendations regarding the following:

(d) Methods for allocation and disbursement of funds, INCLUDING A RANGE OF OPTIONS FOR REIMBURSING PROVIDERS IN THE PROGRAM, WHICH OPTIONS SHALL INCLUDE, BUT NEED NOT BE LIMITED TO, SYSTEMS OF NONCOST REIMBURSEMENT AND PROSPECTIVE REIMBURSEMENT;

(l) A schedule for implementation of a service delivery plan; ~~to-commence-July-1,-1984;~~

SECTION 7. 26-15-106 (1) (a), (1) (c), (2), (3), (4), (5) (b), (6), (13) (a), and (13) (b) (II), Colorado Revised

Statutes, 1982 Repl. Vol., as amended, are amended to read:

26-15-106. Responsibility of the health sciences center - provider contracts. (1) (a) ~~Execution--of~~ EXECUTING such contracts with providers for payment of costs of medical services rendered to the medically indigent as the health sciences center shall determine are necessary for the continuation of the ~~state-funded-programs--for--the--medically indigent--existing--prior--to--July--1,--1983,--including--any short-term-or-transitional-contracts-and--contract--extensions which-may-be-necessary-to-allow-time-for-promulgation-of-rules and--negotiation-and-execution-of-detailed-contracts;~~ PROGRAM, WHICH CONTRACTS SHALL EACH BE EFFECTIVE FOR ONE YEAR OR LESS;

(c) ~~Submit~~ SUBMITTING the report required in section 26-15-105 (1).

(2) The contracts required by paragraph (a) of subsection (1) of this section shall be negotiated between the health sciences center and the providers and shall include contracts with providers to provide tertiary or specialized services. ~~The--center--may--award--such--contracts--upon--a determination-that-it-would-not-be-cost-effective--nor--result in--adequate-quality-of-care-for-such-services-to-be-developed by-the-contract-providers;-or-upon-a--determination--that--the contract--providers--are--unable--or-unwilling-to-provide-such services;~~ THE HEALTH SCIENCES CENTER MAY REFUSE TO CONTRACT WITH OR TO RENEW A CONTRACT WITH OR MAY REVOKE A CONTRACT WITH A PROVIDER THAT FAILS TO COMPLY WITH RULES AND REGULATIONS PROMULGATED PURSUANT TO THIS ARTICLE. THE HEALTH SCIENCES

CENTER MAY ACT AS A PROVIDER AND MAY REIMBURSE ITSELF FOR PROVIDING MEDICAL SERVICES PURSUANT TO THIS ARTICLE IN ACCORDANCE WITH PARAGRAPH (a) OF SUBSECTION (6) OF THIS SECTION AT A RATE NOT EXCEEDING THAT GIVEN TO OTHER PROVIDERS.

(3) ~~Every contract between~~ THE RULES PROMULGATED BY the health sciences center ~~and a provider~~ shall provide for ~~proof~~ EVIDENCE of indigency, TO THE EXTENT POSSIBLE, to be submitted by the person seeking assistance. ~~but~~ The provider shall be responsible for the determination of eligibility OF APPLICANTS. THE RULES PROMULGATED BY THE HEALTH SCIENCES CENTER SHALL REQUIRE THE PROVIDER TO USE AND ENFORCE AN ABILITY-TO-PAY SCALE CURRENTLY APPROVED BY THE HEALTH SCIENCES CENTER AND A COPAYMENT SCHEDULE CURRENTLY APPROVED BY THE HEALTH SCIENCES CENTER. IN REQUIRING THE USE AND ENFORCEMENT OF A COPAYMENT SCHEDULE, THE GENERAL ASSEMBLY INTENDS THAT EVERY PERSON RECEIVING MEDICAL SERVICES PURSUANT TO THIS ARTICLE PAY SOME PORTION OF THE COST OF PROVIDING SUCH SERVICES. THE HEALTH SCIENCES CENTER SHALL USE SUCH CURRENT ABILITY-TO-PAY SCALE OR SUCH CURRENT COPAYMENT SCHEDULE TO DETERMINE THE EXTENT OF STATE REIMBURSEMENT PURSUANT TO THIS ARTICLE.

(4) (a) Contracts with providers shall reflect medical services rendered to the medically indigent in different regions of the state on a geographic basis.

(b) THE HEALTH SCIENCES CENTER IS AUTHORIZED TO SOLICIT COMPETITIVE BIDS PURSUANT TO PART 2 OF ARTICLE 103 OF TITLE 24, C.R.S., FROM PROVIDERS TO PROVIDE MEDICAL SERVICES

PURSUANT TO THIS ARTICLE. IN THE EVENT THAT THERE IS NO QUALIFIED BID SUBMITTED FOR A PARTICULAR REGION, THE HEALTH SCIENCES CENTER MAY NEGOTIATE BIDS WHICH IT HAS ALREADY RECEIVED, INCLUDE THE AREA IN ANOTHER REGION OR REGIONS, OR ASK FOR NEW BIDS.

(5) (b) The ~~university--of--Colorado~~ health sciences center, including associated physicians, shall be the primary provider of such complex care as is not available or is not contracted for in the ~~remaining-areas-of-the~~ state up to its physical, staff, and financial capabilities as provided for under this program. WHEN NECESSARY TO SUPPLEMENT THE COMPLEX CARE PROVIDED BY THE HEALTH SCIENCES CENTER, ADDITIONAL HOSPITALS MAY BE DESIGNATED BY CONTRACT AS SPECIALIZED PROVIDERS OF COMPLEX CARE.

(6) (a) Contracts with providers shall specify the aggregate level of funding which will be available for the care of the medically indigent. ~~However,-providers--will--not be-funded-at-a-level-exceeding-actual-costs.~~ Each year, funds will be allocated to providers based on the anticipated utilization of services in the respective region, giving due consideration to actual utilization of comparable services within the program (including specialty and tertiary services) in the respective region, for the prior fiscal year. EACH CONTRACT WITH A PROVIDER SHALL PROVIDE FOR THE REIMBURSEMENT OF A PERCENTAGE OF THE AVERAGE COST OF EACH MEDICAL SERVICE PROVIDED. BASED ON AVAILABLE APPROPRIATIONS, THE HEALTH SCIENCES CENTER SHALL PERIODICALLY ADJUST THE PERCENTAGE OF

THE AVERAGE COST OF PROVIDING EACH MEDICAL SERVICE WHICH IT WILL REIMBURSE TO PROVIDERS.

(b) For the fiscal year beginning July 1, ~~1983,--the contract--amounts--for--provision-of-services-to-the-medically indigent--shall---be---those---identified---in---the---general appropriation-bill-as-follows:~~

~~Denver-health-and-hospitals $ 16,340,162~~

~~University-of-Colorado-health sciences-center $ 15,490,596~~

~~Community-maternity-providers $ 1,709,435~~

~~All-other-providers $ 1,509,531~~

1986, AND EACH FISCAL YEAR THEREAFTER THE GENERAL APPROPRIATION ACT SHALL PROVIDE SEPARATE LINE ITEMS FOR EDUCATION AND RESEARCH PROGRAMS FUNDED BY THE STATE AT DENVER HEALTH AND HOSPITALS AND THE HEALTH SCIENCES CENTER. AN ADDITIONAL LINE ITEM SHALL STIPULATE THE AGGREGATE LEVEL OF FUNDING WHICH WILL BE AVAILABLE TO REIMBURSE PROVIDERS UNDER THE PROGRAM PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (6). ALL PROVIDERS OF MEDICAL SERVICES UNDER THE PROGRAM SHALL BE REIMBURSED PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (6) FOR SUCH SERVICES.

(13) (a) Every contract shall require that a medically indigent person who wishes to be determined eligible for assistance under this article shall submit a signed application therefor to the provider or to the health sciences center. A SINGLE DETERMINATION OF ELIGIBILITY SHALL BE VALID FOR NO LONGER THAN ONE YEAR FROM THE DATE OF SUCH

DETERMINATION.

(b) (II) Obtain records pertaining to eligibility from a financial institution, as defined in section 15-15-101 (3), C.R.S., or from any insurance company OR FROM ANY WAGE AND EMPLOYMENT DATA AVAILABLE FROM THE DEPARTMENT OF LABOR AND EMPLOYMENT.

SECTION 8. 26-15-106 (13), Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

26-15-106. Responsibility of the health sciences center - provider contracts. (13) (d) By signing the application, the medically indigent person specifically waives any right to file a civil action for damages arising out of the good faith acts or omissions of any provider who renders medical services to such person pursuant to the provisions of this article.

SECTION 9. 26-15-106, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

26-15-106. Responsibility of the health sciences center - provider contracts. (17) (a) The health sciences center shall not reimburse inpatient services which can be performed less expensively in the outpatient setting.

(b) The following types of medical services are eligible for reimbursement pursuant to this article:

(I) Outpatient emergency care; and

(II) Inpatient hospital care when determined to be immediately necessary.

(c) Except for life-threatening emergencies, the following types of medical services are not eligible for reimbursement pursuant to this article:

(I) Renal dialysis;

(II) Mental health or psychiatric treatment;

(III) Alcoholism or controlled substance abuse treatment;

(IV) Cosmetic surgery, except for reconstructive cosmetic surgery;

(V) Dental care;

(VI) The transportation of patients, except as specifically authorized by the health sciences center; and

(VII) The provision of prescription drugs, except as otherwise provided in this article.

SECTION 10. 26-15-110 (1), Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended to read:

26-15-110. Existing programs included - exceptions - appropriations. (1) It is the intention of the general assembly to incorporate all state-funded programs for the medically indigent existing prior to July 1, 1983, except those programs funded through appropriations to the department of health, into the program established by this article. THE PROGRAM ESTABLISHED BY THIS ARTICLE SHALL NOT DUPLICATE COUNTY OR REGIONAL PROGRAMS FUNDED BY THE DEPARTMENT OF HEALTH.

SECTION 11. Article 15 of title 26, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

26-15-114. Medically indigent program - payor of last resort. All other means of payment shall be exhausted before medically indigent funds are utilized for reimbursement pursuant to this article. The program shall be the payor of last resort.

SECTION 12. Repeal. 26-15-105 (1) (k), 26-15-106 (5) (a), (11), and (12), 26-15-107, 26-15-108, and 26-15-113, Colorado Revised Statutes, 1982 Repl. Vol., as amended, are repealed.

SECTION 13. Effective date. This act shall take effect July 1, 1986.

SECTION 14. 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.

BILL 18

A BILL FOR AN ACT

CONCERNING THE MEDICAL EXPENSES OF QUALIFIED CHILDREN AND PREGNANT WOMEN.

Bill Summary

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

Makes an appropriation to the university of Colorado health sciences center to pay for the medical needs of children under the age of three and pregnant women otherwise unable to afford medical care.

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

SECTION 1. Legislative declaration. (1) The general assembly hereby finds and declares:

(a) That a shortage of public funds exists to provide for the medical needs of Colorado citizens unable to afford medical care;

(b) That the expenditure of public funds for disease prevention and medical complications of children under three years of age and pregnant women is expected to reduce the

costs of and need for future medical assistance for such population;

(c) That, therefore, the general assembly hereby determines that the expenditure of public funds for the prevention of diseases and medical complications of children under three years of age and pregnant women is a cost-effective and desirable way to maximize the benefits of limited tax dollars and provide for the medical needs of those Colorado citizens unable to afford medical care. The general assembly hereby designates the university of Colorado health sciences center, as defined in section 26-15-103 (3), Colorado Revised Statutes, as the receiving agency for such funds, in accordance with the "Reform Act for the Provision of the Health Care for the Medically Indigent", article 15 of title 26, Colorado Revised Statutes.

(d) That, on or before January 15, 1987, the university of Colorado health sciences center shall report to the general assembly on the effectiveness of cost containment pursuant to this section.

SECTION 2. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of higher education for allocation to the university to Colorado for use by the university of Colorado health sciences center, for the fiscal year commencing July 1, 1986, the sum of seven hundred thousand dollars ($700,000), or so much thereof as may be necessary, for implementation of

this act.

SECTION 3. 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.

BILL 19

A BILL FOR AN ACT

CONCERNING SAFETY REQUIREMENTS FOR MOTORCYCLES AND MOTOR-DRIVEN CYCLES.

Bill Summary

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

Adds to the safety standards the requirement that motorcycle or motor-driven cycle operators and passengers wear protective helmets, and states the consequences of noncompliance with the requirement. States that the department of revenue shall adopt standards and specifications regarding the protective helmets. Includes helmet face shields as a source of eye protection.

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

SECTION 1. 42-4-231 (1), Colorado Revised Statutes, 1984 Repl. Vol., is amended to read:

42-4-231. Minimum safety standards for motorcycles and motor-driven cycles. (1) No person shall operate any motorcycle or motor-driven cycle on any public highway in this state unless such person and any passenger thereon HAS IN PLACE ON HIS HELMET A FACE SHIELD OR, IF SUCH HELMET IS

BILL 19

A BILL FOR AN ACT

CONCERNING SAFETY REQUIREMENTS FOR MOTORCYCLES AND MOTOR-DRIVEN CYCLES.

Bill Summary

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

Adds to the safety standards the requirement that motorcycle or motor-driven cycle operators and passengers wear protective helmets, and states the consequences of noncompliance with the requirement. States that the department of revenue shall adopt standards and specifications regarding the protective helmets. Includes helmet face shields as a source of eye protection.

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

SECTION 1. 42-4-231 (1), Colorado Revised Statutes, 1984 Repl. Vol., is amended to read:

42-4-231. Minimum safety standards for motorcycles and motor-driven cycles. (1) No person shall operate any motorcycle or motor-driven cycle on any public highway in this state unless such person and any passenger thereon HAS IN PLACE ON HIS HELMET A FACE SHIELD OR, IF SUCH HELMET IS

WITHOUT A FACE SHIELD, is wearing goggles or eyeglasses with lenses made of safety glass or plastic.

SECTION 2. Part 2 of article 4 of title 42, Colorado Revised Statutes, 1984 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

42-4-231.5. Protective helmet requirement. (1) No person shall operate any motorcycle or motor-driven cycle on any public highway in this state unless such person and any passenger thereon is wearing securely fastened on his head a protective helmet designed to deflect blows, resist penetration, and spread the force of impact. Each such helmet shall be coated with a reflectorized substance or have attached thereto a reflectorized material, on both sides and the back thereof, with a minimum of four square inches of such coated substance or attached material in each of such locations.

(2) The department shall adopt standards and specifications for protective helmets for use by operators of motorcycles or motor-driven cycles and their passengers.

(3) The department may accept the federal motor vehicle safety standards adopted pursuant to the "National Traffic and Motor Vehicle Act of 1966" as the minimum performance and design requirements for protective helmets.

(4) Any person who violates any provision of this section commits a class A traffic infraction.

SECTION 3. Effective date - applicability. This act shall take effect July 1, 1986, and shall apply to offenses

committed on or after said date.

SECTION 4. 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.

BILL 20

A BILL FOR AN ACT

CONCERNING HEALTH BENEFITS PLANS, AND PROVIDING FOR CONTINUED COVERAGE UPON TERMINATION OF EMPLOYMENT.

Bill Summary

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

Requires group sickness and accident insurance policies and group contracts issued by nonprofit hospital, medical-surgical, and health service corporations and by health maintenance organizations to provide for continued coverage of an employee, upon termination of his employment, for a certain period of time. Further requires such policies and contracts to provide that, upon expiration of the continued group coverage, the employee or his spouse or dependent, at his expense, may elect for individual coverage.

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

SECTION 1. 10-8-116 (2) (a) (VII), Colorado Revised Statutes, as amended, is amended, and the said 10-8-116 is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

10-8-116. Group sickness and accident insurance. (2) (a) (VII) A provision that the insurer will issue to the

policyholder, for delivery to each person insured, a certificate, which may be in summary form, setting forth the essential features of the insurance coverage, including any applicable conversion OR CONTINUATION privilege, and to whom the benefits are payable. If family members or dependents are included in the coverage, only one certificate need be issued for each family unit.

(12) (a) An employee shall be eligible to make the election for himself and his dependents provided for in subparagraph (VI) of paragraph (b) of subsection (2) of this section if:

(I) The group policy has been terminated for any reason other than discontinuance of the group policy in its entirety or with respect to an insured class;

(II) Any premium or contribution required from or on behalf of the employee has been paid to the termination date; and

(III) The employee has been continuously insured under the group policy, or under any group policy providing similar benefits which it replaces, for at least six months immediately prior to termination.

(b) The provisions of paragraph (a) of this subsection (12) shall not apply to a policy which provides benefits for specific diseases or for accidental injuries only.

(13) (a) Upon the termination of employment of an eligible employee, the employee has the right to elect to continue the coverage until he becomes reemployed and eligible

for health care coverage under a group policy, contract, or plan sponsored by the same or another employer or for a period of one year after the termination of employment, whichever is shorter. The employer shall notify such employee of his right to continue coverage immediately upon his termination.

(b) The notification required by paragraph (a) of this subsection (13) shall be in writing and either delivered personally to the employee or sent by first class mail to the employee's last known address which the employee has provided the employer. The notification shall inform the employee of:

(I) His right to elect to continue the coverage;

(II) The amount he must pay monthly to the employer to retain the coverage;

(III) The manner in which and the office of the employer to which the payment to the employer must be made;

(IV) The time by which the payments to the employer must be made to retain coverage; and

(V) The probability that coverage will be terminated if timely payment is not made to the employer.

(c) If the group policy which had provided coverage for the terminated employee is administered by a trust, the requirements of paragraphs (a) and (b) of this subsection (13) shall be the responsibility of the trust rather than the employer.

(d) If the employer or trust fails to notify an eligible employee of his right to elect to continue the coverage, the employee shall have the option to retain coverage if, within

sixty days of the date his employment is terminated, he makes the proper payment to the employer or trust to provide continuous coverage.

(e) After timely receipt of the monthly payment from an eligible employee, if the employer, or the trustee if the policy is administered by a trust, fails to make the payment to the insurer, with the result that the employee's coverage is terminated, the employer or the trust shall become liable for the employee's coverage to the same extent as the insurer would be if the coverage were still in effect.

(14) A group sickness and accident insurance policy that provides for continued coverage after an employee is terminated, as required by subparagraph (VI) of paragraph (b) of subsection (2) of this section, shall also include a provision allowing a covered employee or surviving spouse or dependent, at the expiration of such continued coverage, to obtain from the insurer underwriting the group policy, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual policy of sickness and accident insurance.

(15) The provisions of subsections (12) to (14) of this section shall apply to all group policies issued, renewed, or reinstated on and after July 1, 1986.

SECTION 2. 10-8-116 (2) (b), Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SUBPARAGRAPH to read:

10-8-116. Group sickness and accident insurance. (2) (b) (VI) Every group sickness and accident insurance policy included within the provisions of subsection (1) of this section shall contain a provision which permits every covered employee whose employment is terminated, if the policy remains in force for active employees of the employer, to elect to continue the coverage for himself and his dependents. Such provision shall conform to the requirements, where applicable, of subsections (12), (13), and (14) of this section.

SECTION 3. Article 16 of title 10, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-141. Continuation privilege. (1) Every group contract providing hospital services, medical-surgical services, or other health services for subscribers and their dependents issued by a nonprofit hospital, medical-surgical and health service corporation operating with a certificate of authority pursuant to this article shall contain a provision which permits every covered employee whose employment is terminated, if the contract remains in force for active employees of the employer, to elect to continue the coverage for himself and his dependents. Such provision shall conform to the requirements, where applicable, of subsections (2), (3), and (4) of this section.

(2) (a) An employee shall be eligible to make the election for himself and his dependents provided for in

subsection (1) of this section if:

(I) The group contract has been terminated for any reason other than discontinuance of the group contract in its entirety or with respect to an insured class;

(II) Any premium or contribution required from or on behalf of the employee has been paid to the termination date; and

(III) The employee has been continuously covered under the group contract, or under any group contract providing similar benefits which it replaces, for at least six months immediately prior to termination.

(b) The provisions of paragraph (a) of this subsection (2) shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only.

(3) (a) Upon the termination of employment of an eligible employee, the employee has the right to elect to continue the coverage until he becomes reemployed and eligible for health care coverage under a group policy, contract,or plan sponsored by the same or another employer or for a period of one year after termination of employment, whichever is shorter. The employer shall notify such employee of his right to continue coverage immediately upon his termination.

(b) The notification required by paragraph (a) of this subsection (3) shall be in writing and either delivered personally to the employee or sent by first class mail to the employee's last know address which the employee has provided the employer. The notification shall inform the employee of:

(I) His right to elect to continue the coverage;

(II) The amount he must pay monthly to the employer to retain the coverage;

(II) The manner in which and the office of the employer to which the payment to the employer must be made;

(IV) The time by which the payments to the employer must be made to retain coverage; and

(V) The probability that coverage will be terminated if timely payment is not made to the employer.

(c) If the group contract which had provided coverage for the terminated employee is administered by a trust, the requirements of paragraphs (a) and (b) of this subsection (3) shall be the responsibility of the trust rather than the employer.

(d) If the employer or trust fails to notify an eligible employee of this right to continue coverage, the employee shall have the option to retain coverage if, within sixty days of the date his employment is terminated, he makes the proper payment to the employer or trust to provide for continuous coverage.

(e) After timely receipt of payment from an eligible employee, if the employer, or the trustee if the contract is administered by a trust, fails to make the payment to the nonprofit hospital, medical-surgical, and health service corporation, with the result that the employee's coverage is terminated, the employer or the trust shall become liable for the employee's coverage to the same extent as the nonprofit

hospital, medical-surgical, and health service corporation would be if the coverage were still in effect.

(4) A group contract of hospital services, medical-surgical services, or other health services for subscribers and their dependents which provides for continued coverage after an employee is terminated, as required by subsection (1) of this section, shall also include a provision allowing a covered employee or surviving spouse or dependent, at the expiration of such continued coverage, to obtain from the nonprofit hospital, medical-surgical, and health service corporation, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual contract providing hospital services, medical-surgical services, or other health services.

(5) The provisions of subsections (2) to (4) of this section shall apply to all group contracts entered into, renewed, or reinstated on and after July 1, 1986.

SECTION 4. Article 17 of title 10, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SECTION, to read:

10-17-135. Continuation privilege. (1) Every group service contract providing health care services for enrollees and their dependents issued by a health maintenance organization operating with a certificate of authority under the provisions of this article shall contain a provision which permits every enrollee of an employed group whose employment

hospital, medical-surgical, and health service corporation would be if the coverage were still in effect.

(4) A group contract of hospital services, medical-surgical services, or other health services for subscribers and their dependents which provides for continued coverage after an employee is terminated, as required by subsection (1) of this section, shall also include a provision allowing a covered employee or surviving spouse or dependent, at the expiration of such continued coverage, to obtain from the nonprofit hospital, medical-surgical, and health service corporation, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual contract providing hospital services, medical-surgical services, or other health services.

(5) The provisions of subsections (2) to (4) of this section shall apply to all group contracts entered into, renewed, or reinstated on and after July 1, 1986.

SECTION 4. Article 17 of title 10, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SECTION, to read:

10-17-135. Continuation privilege. (1) Every group service contract providing health care services for enrollees and their dependents issued by a health maintenance organization operating with a certificate of authority under the provisions of this article shall contain a provision which permits every enrollee of an employed group whose employment

is terminated, if the contract remains in force for active employees of the employer, to elect to continue the coverage for himself and his dependents. Such provision shall conform to the requirements, where applicable, of subsections (2), (3), and (4) of this section.

(2) (a) An employee shall be eligible to make the election for himself and his dependents provided for in subsection (1) of this section if:

(I) The group contract has been terminated for any reason other than discontinuance of the group contract in its entirety or with respect to an insured class;

(II) Any premium or contribution required from or on behalf of the employee has been paid to the termination date; and

(III) The employee has been continuously covered under the group contract, or under any group contract providing similar benefits which it replaces, for at least six months immediately prior to termination.

(b) The provisions of paragraph (a) of this subsection (2) shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only.

(3) (a) Upon the termination of employment of an eligible employee, the employee has the right to elect to continue the coverage until he becomes reemployed and eligible for health care coverage under a group policy, contract, or plan sponsored by the same or another employer or for a period of one year after termination of employment, whichever is

shorter. The employer shall notify such employee of his right to continue coverage immediately upon his termination.

(b) The notification required by paragraph (a) of this subsection (3) shall be in writing and either delivered personally to the employee or sent by first class mail to the employee's last known address which the employee has provided the employer. The notification shall inform the employee of:

(I) His right to elect to continue the coverage;

(II) The amount he must pay monthly to the employer to retain the coverage;

(III) The manner in which and the office of the employer to which the payment to the employer must be made;

(IV) The time by which the payments to the employer must be made to retain coverage; and

(V) The probability that coverage will be terminated if timely payment is not made to the employer.

(c) If the group contract which had provided coverage for the terminated employee is administered by a trust, the requirements of paragraphs (a) and (b) of this subsection (3) shall be the responsibility of the trust rather than the employer.

(d) If the employer or trust fails to notify an eligible employee of his right to continue coverage, the employee shall have the option to retain coverage if, within sixty days of the date his employment terminated, he makes the proper payment to the employer or trustee to provide for continuous coverage.

(e) After timely receipt of payment from an eligible employee, if the employer, or the trustee if the group contract is administered by a trust, fails to make the payment to the health maintenance organization, with the result that the employee's coverage is terminated, the employer or the trust shall become liable for the employee's coverage to the same extent as the health maintenance organization would be if the coverage were still in effect.

(4) A group contract providing health care services for enrollees and their dependents which provides for continued coverage after an employee is terminated from employment, as required by subsection (1) of this section, shall also include a provision allowing a covered employee or surviving spouse or dependent, at the expiration of such continued coverage, to obtain from the health maintenance organization, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual contract providing health care services.

(5) The provisions of subsections (2) to (4) of this section shall apply to all group contracts entered into, renewed, or reinstated on and after July 1, 1986.

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.

BILL 21

A BILL FOR AN ACT

CONCERNING THE "COLORADO HEALTH INSURANCE POOL ACT".

Bill Summary

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

Creates a state health insurance pool to make health insurance coverage available to residents of the state who are otherwise considered uninsurable. Specifies that health care financing mechanisms (insurers, nonprofit service plan corporations, and HMO's, and self-insurers) shall be members.

Provides that the pool shall not duplicate coverage from any other source, private or public.

Provides that the premium rates shall not exceed two hundred percent of standard risk rates. Provides a one-hundred-percent offset against premium taxes, if any, for assessments against insurers, nonprofit service plan corporations, and HMO's. For all self-insurers, provides an assessment on benefits paid to or on behalf of their employees.

Requires that the mechanics of the pool and the operations and functions of the pool be established under a plan developed by the board of directors of the pool and approved by the commissioner of insurance.

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

SECTION 1. Article 8 of title 10, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW PART

to read:

PART 5

STATE HEALTH INSURANCE POOL

10-8-501. Short title. This part 5 shall be known and may be cited as the "Colorado Health Insurance Pool Act".

10-8-502. Definitions. As used in this part 5, unless the context otherwise requires:

(1) "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to this part 5.

(2) "Board" means the board of directors of the pool.

(3) "Commissioner" means the commissioner of insurance.

(4) "Division" means the division of insurance.

(5) "Employer" means any person, partnership, association, trust, estate, or corporation which employs twenty-five or more individuals who are residents of this state.

(6) "Health insurance" means any policy for the coverage of hospital and medical expenses, any nonprofit health care service plan contract, and any health maintenance organization subscriber contract. The term does not include short term and long term disability, dental, accident, fixed indemnity, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workmen's compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability

insurance policy or equivalent self-insurance.

(7) "Health maintenance organization" has the same meaning as that set forth in section 25-3-503 (5), C.R.S.

(8) "Insurer" means any entity authorized by the division to transact health insurance business in Colorado.

(9) "Member" means all insurers and self-insurers participating in the pool.

(10) "Physician" means a person licensed pursuant to the provisions of section 12-36-107, C.R.S.

(11) "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of self insurance, individual accident and health insurance policies, group accident and health insurance policies, coverage under a nonprofit health service plan, or coverage under a health maintenance organization subscriber contract.

(12) "Plan of operation" means the plan of operation of the pool, including articles, bylaws, and operating rules adopted by the board pursuant to this part 5.

(13) "Pool" means the Colorado health insurance pool as created in section 10-8-503.

(14) "Self-insurance" means a plan of health coverage offered by a self-insurer.

(15) "Self-insurer" means an employer, an employee welfare benefit fund or plan, a multiple employer welfare arrangement or trust, or a health and welfare trust which directly or indirectly provides a plan of health coverage, which is not totally underwritten by an insurer, to its

employees and their dependents or others pursuant to collective bargaining, an employment agreement, or as an employment benefit, and administers the plan of health coverage itself or through an insurer, trust, or agent.

10-8-503. Operation of the pool. (1) There is hereby created a nonprofit entity to be known as the Colorado health insurance pool. All insurers issuing health insurance in this state on or after July 1, 1986, and all self-insurers providing a plan of health coverage on or after July 1, 1986, shall be members of the pool or shall pay the fee required by section 10-8-510.

(2) The commissioner shall, on or before October 1, 1986, give notice to all insurers and self-insurers of the time and place for the initial organizational meeting of the pool. The commissioner shall appoint the initial board of directors, which shall have nine members, subject to approval by the pool members. The terms of the initial board members shall be such that the successors thereof appointed by the commissioner shall serve staggered terms of four years each. The commissioner shall be a member of the pool and shall also serve as the chairman of the board or shall designate such chairman. The board shall, to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic nonprofit health care service plan, one representative of a health maintenance organization, one representative of a self-insurer, and one member of the

general public who is not associated with the medical profession, a hospital, or an insurer.

(3) The board shall submit to the commissioner a plan of operation to assure the fair, reasonable, and equitable administration of the pool. The commissioner shall, after notice and hearing, approve the plan of operation if the plan will assure the fair, reasonable, and equitable administration of the pool and if the plan provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall be effective upon approval in writing by the commissioner. If the board fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board, or at any time thereafter fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules and regulations as are necessary or advisable to effectuate the provisions of this part 5. Such rules and regulations shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner.

(4) In its plan, the board shall:

(a) Establish procedures for the handling and accounting of assets and moneys of the pool;

(b) Select an administering organization in accordance with this part 5;

(c) Establish procedures for collecting assessments from all members and all non-members to cover pool losses and

expenses incurred under the plan during the period for which the assessment is made. The level of payments shall be established by the board, pursuant to this part 5. Assessment shall occur at the end of each fiscal year. Assessments are due and payable within thirty days of receipt of the assessment notice.

(d) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and the procedures for enrollment and to maintain public awareness of the plan;

(e) Establish procedures for assuring that only appropriate medical care is rendered to enrollees and that such care is rendered in an efficient cost-effective manner;

(f) Establish procedures to provide for payments of claims on a capitated noncost-driven basis.

(5) The pool shall have the general powers and authority granted under the laws of Colorado to insurance companies licensed to transact the kinds of insurance defined under this article and, in addition, the power to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this part 5, including the power, with the approval of the commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions

necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

(c) Take such legal actions as are necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserves and formulas, and any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience, and the expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.

(e) Assess members of the pool in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments are to be credited as offsets against any regular assessments due following the close of the fiscal year.

(f) Issue policies of insurance in accordance with the requirements of this part 5;

(g) Appoint from among members appropriate legal, actuarial, and other committees as are necessary to provide

technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool;

(h) Borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets.

(i) Enter into reinsurance agreements and establish rules, conditions, and procedures for reinsuring risks under this part 5.

10-8-504. Eligibility. (1) Any person who is a resident of this state shall be eligible for pool coverage if evidence is provided that:

(a) The person has been refused health coverage for health reasons;

(b) The person can acquire health coverage only with a reduction or exclusion of coverage for a preexisting health condition, for a period exceeding six months; or

(c) The person can acquire health coverage only at a rate exceeding the pool rate.

(2) A person shall not be eligible for coverage under the pool if:

(a) He has, on the date of coverage by the pool, coverage under any other health insurance or insurance arrangement;

(b) He is, at the time of pool application, eligible for health care benefits under article 4 of title 26, C.R.S.

(c) He has terminated coverage in the pool, unless twelve months have lapsed since such termination;

(d) The pool has paid out five hundred thousand dollars in benefits in his behalf;

(e) He is an inmate of a public institution or is eligible for or currently receiving health or accident benefits from any publicly funded program;

(f) He has failed to pay the appropriate premium costs.

10-8-505. Administering organization. (1) The board shall select an organization through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board. The board shall consider the following:

(a) The organization's proven ability to administer individual accident and health insurance;

(b) The efficiency of the organization's claim-paying procedures;

(c) An estimate of total charges for administering the plan;

(d) The organization's ability to administer the pool in a cost-effective manner.

(2) (a) The administering organization shall serve for a period of three years subject to removal for cause by the commissioner.

(b) At least one year prior to the expiration of each three-year period of service by an administering organization, the board shall invite all organizations, including the

current administering organization, to submit bids to serve as the administering organization for the succeeding three-year period. Selection of the administering organization for the succeeding period shall be made at least six months prior to the end of the current three-year period.

(3) (a) The administering organization shall perform all eligibility and administrative claims payment functions relating to the pool.

(b) The administering organization shall establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the board.

(c) The administering organization shall perform all necessary functions to assure timely payment of benefits to covered persons under the pool, including:

(I) Making information available to the pool about the proper manner of submitting a claim for benefits and distributing forms upon which submission shall be made;

(II) Evaluating the eligibility of each claim for payment by the pool.

(d) The administering organization shall submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be determined by the board.

(e) Following the close of each calendar year, the administering organization shall determine net written and earned premiums, the expense of administration, and the paid

and incurred losses for the year and report this information to the board and the division on a form prescribed by the commissioner.

(f) The administering organization shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

10-8-506. Self-insurer identification and reporting. (1) All self-insurers shall be required to report annually to the commissioner that they are engaged in the business of self-insurance. These reports shall be for the previous calendar year and shall include the self-insurer's total cost of self-insurance, the total benefits paid during the year, and other information the commissioner may by rule require relating to the self-insurer's plan of health coverage. Upon request of the commissioner, the executive director of the department of revenue shall cooperate with the commissioner in the identification of self-insurers and shall modify forms and promulgate rules as may be necessary to identify self-insurers.

(2) In the event that a self-insurer fails to comply with subsection (1) of this section, none of the self-insurer's costs for health benefits shall qualify as an income tax deduction in determining such self-insurer's Colorado adjusted gross income as defined in section 39-22-110, C.R.S., or such self-insurer's net income as defined in section 39-22-304, C.R.S.

10-8-507. Assessments. (1) (a) Following the close of

each fiscal year, the administering organization shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration, and the incurred losses for the year, taking into account investment income, fees paid pursuant to section 10-8-510, and other appropriate gains and losses. Health insurance premiums, self-insured benefits, and subscriber contract charges producing assessments that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

(b) Each insurer's or self-insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in Colorado during the preceding calendar year or one hundred five percent of the benefits paid in Colorado by a self-insurer during the preceding calendar year and the denominator of which equals the total of all premiums and subscriber contract charges written in Colorado during the preceding calendar year plus one hundred five percent of the total benefits paid in Colorado by all self-insurer members during the preceding calendar year.

(2) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection (2),

"future losses" includes reserves for incurred but unreported claims.

(3) (a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed with the board by the member.

(b) Any deficit incurred by the pool shall be recouped by assessments apportioned among members by the board pursuant to subsection (1) of this section.

(4) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (1) of this section. The member receiving such abatement or deferment shall remain liable to the pool.

10-8-508. Minimum benefits - availability. (1) The pool shall offer medical expense coverage for services set out pursuant to subsection (2) of this section to every eligible person. Medical expense coverage offered by the pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under paragraph (d) of subsection (4) of this section, up to a lifetime limit of five hundred thousand dollars per covered

individual. The maximum limit under this subsection (1) shall not be altered by the board, and no actuarial equivalent benefit shall be substituted by the board.

(2) For purposes of this section, covered expenses shall be determined by the board for the following services and articles when necessary and prescribed by a person licensed by state law:

(a) Hospital services;

(b) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a physician or chiropractor, or by other licensed professionals at his direction;

(c) Drugs requiring a physician's prescription;

(d) Services of a licensed skilled nursing facility for not more than one hundred twenty days during a policy year;

(e) Services of a home health agency up to a maximum of two hundred seventy services per year;

(f) Use of radium or other radioactive materials;

(g) Oxygen;

(h) Anesthetics;

(i) Prostheses, other than dental;

(j) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the condition for which such equipment is prescribed;

(k) Diagnostic X-rays and laboratory tests;

(l) Oral surgery for excision of partially or completely

unerupted impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(m) Services of a physical therapist;

(n) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(o) Inpatient or outpatient psychiatric services; except that payment from the pool shall not exceed two thousand dollars for all such services.

(3) Covered expenses shall not include the following:

(a) Any charges for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congential bodily defect to restore normal bodily functions;

(b) Care which is primarily for custodial or domiciliary purposes;

(c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician;

(d) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary;

(e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;

(f) Any expense incurred prior to the effective date of coverage by the pool for the person on whose behalf the expense is incurred;

(g) Dental care, except as provided in paragraph (l) of subsection (2) of this section;

(h) Eyeglasses and hearing aids;

(i) Illness or injury due to acts of war;

(j) Services of blood donors and any fee for failure to replace the first three pints of blood provided to an eligible person each policy year;

(k) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service;

(l) Radial keratotomy;

(m) Experimental procedures;

(n) Other services as determined by the board.

(4) (a) Premiums charged for coverages issued by the pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

(b) Separate schedules of premium rates based on age and geographical location may apply for individual risks.

(c) The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall

be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be more than one hundred fifty percent of rates established as applicable for individual standard risks. Rates subsequently established shall provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income or claim reserves, and any other cost factors. In no event shall pool rates exceed two hundred percent of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the commissioner for approval.

(d) The pool coverage defined in this section shall provide for a choice of deductibles of two hundred fifty dollars, five hundred dollars, one thousand dollars, or any other deductible amount determined by the board per annum per individual, and coinsurance of twenty percent, such coinsurance and deductibles in the aggregate not to exceed one thousand five hundred dollars per individual nor three thousand dollars per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the medical component of the consumer price index.

(5) (a) Pool coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition, if:

(I) The condition has manifested itself within the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinarily prudent

person to seek diagnosis, care, or treatment; or

(II) Medical advice, care, or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage.

(b) Such preexisting condition exclusions shall be waived to the extent that similar exclusions have been satisfied under any prior health insurance coverage which was involuntarily terminated if the application for pool coverage is made not later than sixty days following the involuntary termination. In such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated. The board may assess an additional premium of up to ten percent for coverage provided under the plan in this manner, notwithstanding the premium limitations stated in this part 5.

(6) (a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workmen's compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except medicaid.

(b) The pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from

the pool may be reduced or refused as a setoff against any amount recoverable under this paragraph (b).

10-8-509. Collective action. Participation in the pool as members, the establishment of rates, forms, or procedures, or any other joint or collective action required or allowed by this part 5 shall not be the basis of any legal action, criminal or civil liability, or penalty against the pool or any of its members.

10-8-510. Fees assessed on nonparticipating entities. Notwithstanding any other provision of law, every insurer doing business in this state that is not a member of the pool shall, on January 1, 1987, and each January 1 thereafter, pay to the pool a fee equal to three one-hundredths of one percent of gross premiums on health benefits it provides in Colorado for the prior calendar year. Every self-insurer that is not a member of the pool, shall, on January 1, 1987, and each January 1 thereafter, pay to the pool a fee equal to three and fifteen-hundredths percent of the total benefits it pays or provides in this state for the prior calendar year.

10-8-511. Taxation. (1) The pool established pursuant to this part 5 shall be exempt from any and all taxes assessed by the state of Colorado.

(2) Any insurer subject to tax liability imposed by section 10-3-209 may offset one hundred percent of the assessments paid to the pool by it in a calendar year against such tax liability.

10-8-512. Notice of pool. Every insurer shall give

notice of the existence of the Colorado health insurance pool, when such pool is operative, to any applicant for health insurance coverage whose application for coverage is denied on or after July 1, 1986, because of the applicant's health.

10-8-513. Pool study. After two years of operation of the pool, the board shall conduct a study of the claims loss experience of the pool and adjust the plan of operation and benefits plan to reflect the findings of the study with the approval of the commissioner. The board may also recommend amendments to this part 5 to the general assembly to address the claims loss experience of the pool.

SECTION 2. Effective date. This act shall take effect July 1, 1986.

SECTION 3. 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.

BILL 22

A BILL FOR AN ACT

CONCERNING THE TAXATION OF HEALTH CARE FINANCING PLANS.

Bill Summary

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

Provides that earned premiums received for insurance coverage by fraternal and benevolent associations, nonprofit hospital and health service corporations, and health maintenance organizations shall no longer be exempt from taxation. Provides that earned premiums received for coverage of health, sickness, or accidents which is supplemental to medicare coverage are not taxable. Requires foreign group insurers delivering health insurance master policies out of state to provide Colorado statutory benefits to Colorado residents insured by such policies and pay pro rata taxes for revenue generated by such Colorado insureds.

Provides that benefits from employee welfare benefit plans shall be subject to taxation.

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

SECTION 1. 10-3-209 (1) (d) (I), Colorado Revised Statutes, is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

10-3-209. Tax on premiums collected - exemptions - penalties. (1) (d) (I) The amount of all earned premiums collected or contracted for by an insurance company on health,

sickness, and accident policies, or contracts of insurance therefor, shall be exempt from the taxes provided for under this subsection (1) when said policies or contracts are sold as medicare supplemental insurance to persons eligible for retirement benefits under Title 18 of the federal "Social Security Act".

SECTION 2. Part 2 of article 3 of title 10, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

10-3-209.5. Employee welfare benefit plans - definitions - imposition of tax. (1) As used in this section, "employee welfare benefit plan" means any plan, fund, or program which is communicated or its benefits described in writing to employees and which is established by or on behalf of any individual, partnership, association, corporation, trustee, legal representative, employer or employee organization, or any other organized group for the purpose of providing for employees or their dependents through such individual, partnership, association, corporation, trustee, legal representative, employer or employee organization, or any other group, medical, surgical, or hospital benefits, in cash or in the form of care, service, or supplies, or other benefits in the event of sickness, accident, or disability. An employee welfare benefit plan shall not include the following:

(a) That portion of any such plan with respect to which benefits are insured by an insurance company, a nonprofit

hospital, medical-surgical, and health service corporation, a health maintenance organization, or any combination thereof;

(b) Any such plan covering less than ten employees in this state;

(c) Any such plan established and maintained as a pension or profit-sharing plan for the exclusive benefit of employees and their beneficiaries;

(d) Any such plan established and maintained for the purpose of complying with the "Workmen's Compensation Act of Colorado", articles 40 to 54 of title 8, C.R.S., or with any workmen's compensation law of the federal government or of any other state;

(e) Any such plan administered by or for the federal government, the government of a state, a political subdivision of a state, or any agency or instrumentality of any such government or political subdivision;

(f) Any such plan with respect to payments by an employer continuing an employee's regular compensation, or part thereof, during an illness or a disability; or

(g) Any such plan which is primarily for the purpose of providing first-aid care and treatment, at a dispensary of an employer, for injury or sickness of employees while engaged in their employment.

(2) There is hereby imposed, with respect to each employee welfare benefit plan, an annual tax payable by the individual, partnership, association, corporation, trustee, legal representative, employer or employee organization, or

any other organized group maintaining such plan. Such tax shall be payable to the division of insurance on or before March 1 of each year and shall be determined by applying the rate of tax to the amounts paid as benefits to or on behalf of residents of this state, during the next preceding calendar year, by or on behalf of such individual, partnership, association, corporation, trustee, legal representative, employer or employee organization, or any other organized group under such plan in this state. With respect to benefits paid because of sickness, accident, or disability, the rate of tax shall be three percent. The provisions of this part 2 pertaining to the filing of returns, payment, assessment and collection of taxes, and penalties imposed on insurance companies shall apply in respect to the tax imposed by this section.

(3) All taxes collected by the division of insurance pursuant to this section shall be transmitted to the state treasurer who shall credit the same to the general fund.

SECTION 3. 10-3-903 (2) (f), Colorado Revised Statutes, is amended to read:

10-3-903. Definition of transacting insurance business. (2) (f) Transactions in this state involving group life and group sickness and accident or blanket sickness and accident insurance or group annuities where the master policy of such groups was lawfully issued and delivered in a state in which the company was authorized to do an insurance business IF THE COVERAGES FOR COLORADO RESIDENTS OF SUCH POLICIES MEET THE

REQUIREMENTS OF THIS TITLE. PREMIUM TAXES SHALL BE PAID TO THIS STATE PRO RATA ACCORDING TO EARNED PREMIUMS RECEIVED FROM INSURING SUCH COLORADO RESIDENTS.

SECTION 4. 10-14-133, Colorado Revised Statutes, is amended to read:

10-14-133. Taxation. Every fraternal benefit society organized or licensed under this article is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all state, county, district, municipal, and school taxes, other than taxes IMPOSED ON EARNED PREMIUMS PURSUANT TO SECTION 10-3-209 AND TAXES on real estate and office equipment.

SECTION 5. 10-16-120, Colorado Revised Statutes, as amended, is amended to read:

10-16-120. Examinations and investigations. The commissioner, or any person authorized by him, has the power to examine the financial condition, affairs, and management of any corporation subject to the provisions of this article. For such purpose he has free access to all the books, papers, and documents relating to the business of the corporation and may summon witnesses and administer oaths and affirmations in the examination of the directors, trustees, officers, agents, representatives, or employees of such corporation or any other person in relation to its affairs, transactions, and conditions. The commissioner shall make an examination of each corporation subject to the provisions of this article at least once every three years. ~~and--the--corporation--examined~~

~~shall pay to the commissioner the cost of such examination, as determined by the commissioner.~~

SECTION 6. Article 16 of title 10, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-141. Payment of taxes on premiums. Every corporation subject to the provisions of this article shall pay to the division of insurance taxes on subscriber premiums earned for coverages insured determined in accordance with the computation of insurance premium taxes payable by insurers pursuant to section 10-3-209.

SECTION 7. Article 17 of title 10, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

10-17-135. Payment of taxes on premiums. Every health maintenance organization subject to the provisions of this article shall pay to the division of insurance taxes collected on earned premiums pursuant to section 10-3-209.

SECTION 8. Repeal. 10-16-129 and 10-17-118 (4), Colorado Revised Statutes, as amended, are repealed.

SECTION 9. Effective date - applicability. This act shall take effect January 1, 1987. Sections 1 and 3 to 8 shall apply to all contracts of insurance involving health, sickness, and accident coverage entered into or renewed, or such contracts in which insurers may increase rates on such coverage, on or after said date. Section 2 shall apply to all employee welfare benefit plans existing on said date or

entered into on or after said date.

SECTION 10. 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.

BILL 23

A BILL FOR AN ACT

CONCERNING DEDUCTIONS FROM RESIDENT INDIVIDUALS' COLORADO ADJUSTED GROSS INCOMES FOR CONTRIBUTIONS MADE TO INDIVIDUAL MEDICAL ACCOUNTS.

Bill Summary

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

Allows a specified deduction per taxable year from Colorado adjusted gross income for contributions to an individual medical account which pays the medical and dental expenses of the account holder. Requires the account to be managed as a trust. Imposes a tax penalty for withdrawals before a designated time period. Allows withdrawals for medical and dental purposes only after a certain age. Requires the account to become part of the account holder's taxable estate upon his death.

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

SECTION 1. Part 5 of article 22, of title 39, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF THE FOLLOWING NEW SECTIONS to read:

39-22-504.5. Short title. Sections 39-22-504.5 to 39-22-504.7 shall be known and may be cited as the "Individual

Medical Account Act of 1986".

39-22-504.6. Definitions. As used in sections 39-22-504.5 to 39-22-504.7, unless the context otherwise requires:

(1) "Account holder" means the individual on whose behalf the individual medical account is established.

(2) "Dependent child" means any person under the age of twenty-one years or any person who is legally entitled to or the subject of a court order for the provision of proper or necessary subsistence, education, medical care, or any other care necessary for his health, guidance, or well-being and who is not otherwise emancipated, self-supporting, married, or a member of the armed forces of the United States, or who is so mentally or physically incapacitated that he cannot provide for himself.

(3) "Individual medical account" means a trust created or organized in the state of Colorado to pay the eligible medical and dental care expenses of the account holder.

(4) "Trustee" means a chartered state bank, savings and loan association, or trust company authorized to act as fiduciary and under the supervision of the state bank commissioner or the state commissioner of savings and loan associations; a national banking association or federal savings and loan association authorized to act as fiduciary in Colorado; or an insurance company.

39-22-504.7. Individual medical accounts - eligibility. (1) For taxable years beginning on or after January 1, 1986,

a resident individual shall be allowed to deduct from his Colorado adjusted gross income contributions he makes to his individual medical account. The amount allowed as a deduction per taxable year shall not exceed:

(a) Two thousand dollars for the account holder;

(b) Two thousand dollars for the spouse of the account holder;

(c) One thousand dollars for each dependent child of the account holder.

(2) The account shall be established as a trust under the laws of Colorado and placed with a trustee. The trustee shall:

(a) Purchase major medical coverage for each account holder to cover all medical expenses in excess of ten thousand dollars annually;

(b) Utilize the trust assets solely for the purpose of paying the medical and dental expenses of the account holder.

(3) The account holder shall be subject to the following restrictions:

(a) The account holder is responsible for the first one hundred dollars of medical or dental expenses incurred per taxable year.

(b) All medical and dental expenses incurred after payment of the one-hundred-dollar deductible shall be submitted by the account holder to the trustee for payment.

(c) After an individual medical account has accumulated five thousand dollars, an account holder shall not be eligible

for other health insurance coverage, except major medical coverage purchased pursuant to paragraph (a) of subsection (2) of this section.

(4) Individual medical account funds may be withdrawn by the account holder at any time for any purpose, subject to the following restrictions and penalties:

(a) There shall be an early distribution penalty of ten percent of the withdrawn funds for early withdrawal of the account funds by the account holder.

(b) After an account holder reaches the age of fifty-nine and one-half years, withdrawals shall be permitted for medical or dental purposes only and may be withdrawn without penalty.

(5) Upon the death of the account holder, the account principal, as well as any accumulated interest thereon, shall be distributed to the decedent's estate and taxed as part of his estate, as provided by law.

SECTION 2. 39-22-110 (3), Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

39-22-110. Colorado adjusted gross income of a resident individual. (3) (u) Amounts contributed to individual medical accounts, as defined in sections 39-22-504.5 to 39-22-504.7.

SECTION 3. 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.

BILL 24

A BILL FOR AN ACT

CONCERNING INFORMED CONSENT TO MEDICAL PROCEDURES.

Bill Summary

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

Creates the Colorado committee on informed consent to assist the state board of medical examiners in adopting and promulgating a doctrine of informed consent to assist physicians in providing sufficient information to their patients relating to the likely consequences of proposed diagnostic or surgical procedures. Provides that the committee shall consist of three members, appointed by the board, one of whom shall be a licensed physician, one of whom shall be a licensed attorney, and one of whom shall be mutually agreeable to and recommended by the other two members of the committee.

Provides that any patient signing a statement of informed consent prior to the performance of a proposed procedure, which statement complies with rules and regulations promulgated by the state board of medical examiners, shall have no cause of action for lack of informed consent against a physician also signing the statement.

States that signing such a statement of informed consent does not bar an action against a physician for negligence.

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

SECTION 1. Article 36 of title 12, Colorado Revised Statutes, 1985 Repl. Vol., is amended BY THE ADDITION OF A

NEW SECTION to read:

12-36-104.5. Committee on informed consent - created - doctrine of informed consent - adoption and promulgation by board. (1) (a) There is hereby created the Colorado committee on informed consent, referred to in this section as the "committee", which shall assist the board in adopting and promulgating a statement of informed consent to assist physicians in providing sufficient information to their patients relating to the likely consequences of proposed procedures to be performed on those patients. The committee shall consist of three members, appointed by the board, one of whom shall be a licensed physician, one of whom shall be a licensed attorney, and one of whom shall be mutually agreeable to and recommended to the board by the other two members of the committee. Each member shall serve at the pleasure of the board.

(b) Committee members, while serving on business of the committee, shall be reimbursed for their actual and necessary traveling and subsistence expenses while serving away from their places of residence.

(c) The committee shall meet as often as necessary on call of two of its members and shall direct the board in carrying out the purpose of this section.

(2) The committee shall adopt a doctrine of informed consent, which shall specify what information is sufficient for physicians to provide to their patients relating to the likely consequences of procedures which physicians intend to

perform on those patients. The committee shall present such doctrine to the board for its consideration. Once the board adopts and promulgates a doctrine of informed consent under the provisions of section 24-4-103, C.R.S., such doctrine may be applied pursuant to part 3 of article 20 of title 13, C.R.S.

SECTION 2. Part 3 of article 20 of title 13, Colorado Revised Statutes, is RECREATED AND REENACTED, WITH AMENDMENTS, to read:

PART 3

INFORMED CONSENT TO MEDICAL PROCEDURES

13-20-301. Definitions. As used in this part 3, unless the context otherwise requires:

(1) "Board" means the Colorado state board of medical examiners created pursuant to section 12-36-103, C.R.S.

(2) "Colorado committee on informed consent" means the committee appointed by the board pursuant to section 12-36-104.5, C.R.S.

(3) "Informed consent" means the consent which a reasonable and prudent person would give to a proposed procedure after said person has received sufficient information relating to said proposed procedure, which information is in compliance with the current statement of informed consent as adopted and promulgated in rules and regulations by the board.

(4) "Patient" means the person upon whom a proposed procedure is to be performed and, if the patient is unable to

communicate or is under the influence of drugs, includes the patient's spouse, adult son or daughter, parent, adult brother or sister, or legal guardian, in said order of preference, if possible.

(5) "Physician" means a person licensed to practice medicine or osteopathy.

(6) "Procedure" means a diagnostic procedure which involves invasion or disruption of the integrity of the body or any surgical operation which is arranged or scheduled at least twelve hours prior to the time of performance. The term does not include venipuncture.

13-20-302. Statement of informed consent to procedure - requirements. At any time prior to performance of a proposed procedure, a physician may provide his patient with a written statement of informed consent containing sufficient information relating to the likely consequences of the procedure in compliance with rules and regulations adopted and promulgated by the board, as assisted by the committee, pursuant to section 12-36-104.5, C.R.S. If the physician and the patient both sign the statement, the statement shall become effective for purposes of section 13-20-303.

13-20-303. Statement of informed consent - effect on action for lack of informed consent - effect on action for negligence. (1) Any patient signing a statement of informed consent completed in accordance with the requirements of section 13-20-302 regarding a particular procedure shall have no cause of action for lack of informed consent against a

physician also signing the statement.

(2) Proof that a physician has complied with section 13-20-302 with regard to a particular procedure does not bar an action against said physician for negligent performance of said procedure.

SECTION 3. Repeal. 13-20-102, Colorado Revised Statutes, as amended, is repealed.

SECTION 4. 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.

BILL 25

A BILL FOR AN ACT

CONCERNING A PRETRIAL PANEL REQUIREMENT FOR MEDICAL MALPRACTICE CLAIMS.

Bill Summary

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

Requires that all personal injury and wrongful death claims for damages arising out of the provision of or alleged failure to provide health care as specified in a complaint filed in a civil action receive pretrial consideration from a panel appointed by the presiding judge.

Provides that the judge shall appoint the three-member panel from a list maintained by the judicial department. Specifies criteria for each member of the panel.

Sets out procedures for the implementation, administration, and conduct of pretrial panel proceedings. Grants authority to the supreme court to promulgate such rules and regulations as may be necessary to further implement and administer the pretrial panel proceedings. Specifies that the proceedings shall be confidential and informal and that evidence of the proceedings and their results, opinions, findings, and determinations shall not be admissible as evidence in a subsequent trial.

Provides that the panel shall determine whether or not each claim against each health care provider has merit, and, if meritorious, the panel shall render an assessment of a reasonable and fair amount to settle each such claim. Provides that the panel's assessment may have the following effect on a subsequent trial: (1) If the defendant makes a formal offer to settle a claim or claims for the same total amount as rendered by the panel regarding the same claim or

claims and such offer is not accepted by the plaintiff and if the plaintiff subsequently brings such claim or claims to trial and receives a judgment which is less than ten percent over the total settlement amount rendered by the panel for the same claim or claims, then the defendant shall be entitled to recover the actual reasonable costs and attorney fees incurred from the date of filing the action; or (2) If the plaintiff makes a formal offer to settle a claim or claims for the same total amount as rendered by the panel regarding the same claim or claims and such offer is not accepted by the defendant and if the plaintiff subsequently brings such claim or claims to trial and receives a judgment which is less than ten percent under the total settlement amount rendered by the panel for the same claim or claims, then the plaintiff shall be entitled to recover the actual reasonable costs and attorney fees incurred from the date of filing the action.

Authorizes the judicial department to charge fees to cover the total direct and indirect costs of pretrial panel proceedings. Establishes the medical malpractice panel cash fund for the crediting and maintenance of such fees.

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

SECTION 1. Article 20 of title 13, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW PART to read:

PART 5

PRETRIAL PANEL REQUIREMENT FOR MEDICAL MALPRACTICE CLAIMS

13-20-501. Definitions. As used in this part 5, unless the context otherwise requires:

(1) (a) "Health care provider" means any:

(I) Licensed or certified hospital, health care facility, dispensary, or other institution located in Colorado for the treatment or care of the sick or injured; or

(II) Person licensed in this state to practice medicine, osteopathy, chiropractic, nursing, physical therapy, podiatry, dentistry, pharmacy, optometry, or other healing arts, or any

partnership of such persons, or any professional corporation whose shareholders are such persons.

(b) The term "health care provider" does not include any nursing service or nursing facility conducted by and for those who rely upon treatment by spiritual means alone in accordance with the creed or tenets of any well-recognized church or religious denomination.

(2) "Panel" means a pretrial panel created pursuant to section 13-20-502.

13-20-502. Pretrial panel requirement - procedure for requesting - composition of panel. (1) The supreme court shall establish rules and regulations to provide procedures for pretrial consideration of personal injury and wrongful death claims for damages arising out of the provision of or alleged failure to provide health care. After the filing of a complaint in a civil action regarding such a personal injury or wrongful death claim in a county or district court, these procedures shall be compulsory as a condition precedent to commencing a trial in such court. Otherwise, except as provided for in section 13-20-507, the procedures shall be informal and nonbinding. All proceedings conducted under the authority of this part 5 shall be confidential, privileged, and immune from civil process.

(2) As a condition precedent to going to trial in a medical malpractice action for damages for personal injury or wrongful death, a party intending to go to trial shall first be required to file a request for panel review with the

presiding judge. The request shall be mailed to all health care providers named in the complaint.

(3) The presiding judge shall appoint an appropriate panel or panels from a list maintained by the judicial department to accept and hear complaints of negligence and damages made by or on behalf of any patient who is an alleged victim of negligence. Each panel shall be composed of:

(a) One member who is currently licensed to practice law in this state and who shall serve as chairman of the panel;

(b) One member who is a health care provider as currently licensed to practice defined in section 13-20-501 (1) (a) (II) and who practices in the same specialty as the proposed defendant or, in claims against only health care providers as defined in section 13-20-501 (1) (a) (I) or their employees, one member who is an individual currently serving in the administration of such an institutional health care provider; and

(c) One member who is not a lawyer, a health care provider, or an employee of a health care provider and who is selected and appointed by a unanimous decision of the members comprising the panel.

(4) Each person selected as a panel member shall certify under oath that he is without bias or conflict of interest with respect to any matter under consideration.

(5) Members of the panels shall receive per diem compensation and travel expenses for attending panel hearings.

13-20-503. Proceedings before pretrial panel. (1) The

presiding judge shall appoint a panel to consider the claim and set the matter for panel review immediately upon receipt of a request. A panel retains jurisdiction of any claim for ninety days from the date of filing the request. The jurisdiction of the panel may be extended and the proceeding may continue for thirty-day periods upon written agreement of all parties and the members of the panel.

(2) Parties may be represented by counsel in proceedings before a panel.

(3) A party shall be entitled to attend, personally or with counsel, and participate in the proceedings, except upon special order of the panel and unanimous agreement of the parties. Such participation may include the filing of briefs and affidavits. The proceedings shall be confidential and closed to the public. No party shall have the right to cross-examine, rebut, or demand that customary formalities of civil trials and court proceedings be followed. The panel may, however, request special or supplemental participation of some or all parties in particular respects. Communications between the panel and the parties, except the testimony of the parties on the merits of the dispute, shall be disclosed to all other parties.

(4) No record of the proceedings is required. At the end of each proceeding, all evidence, documents, and exhibits shall be returned to the parties or witnesses who provided them. The panel shall have the authority to issue subpoenas and to administer oaths, and any expenses incurred by the

panel in this regard shall be paid by the requesting party, including, but not limited to, witness fees and mileage. The proceedings shall be informal, and formal rules of evidence shall not be applicable. There shall be no discovery or perpetuation of testimony in the proceedings, except upon special order of the panel and for good cause shown demonstrating extraordinary circumstances.

13-20-504. Determinations by the pretrial panel. The panel shall determine on the basis of the evidence whether or not each claim against each health care provider has merit and, if meritorious, the panel shall render an assessment of a reasonable and fair amount to settle each such claim. The panel shall render its opinion in writing not later than thirty days after the end of the proceedings. The opinion shall be sent to all parties by certified mail, return receipt requested.

13-20-505. Evidence and testimony in subsequent actions - immunity of panelists. Evidence of the proceedings conducted by the panel and its results, opinions, findings, and determinations are not admissible as evidence in a subsequent trial. No panelist may be compelled to testify in a subsequent trial or civil action with regard to the subject matter of the panel's review. A panelist shall have immunity from civil liability arising from participation as a panelist and for all communications, findings, opinions, and conclusions made in the course and scope of duties prescribed by this part 5.

13-20-506. Rule-making authority. The supreme court shall promulgate such rules and regulations as may be necessary to provide for the implementation and administration of this part 5.

13-20-507. Formal offer to settle claim - effect on subsequent trial. (1) If the defendant makes a formal offer to settle a claim or claims for the same total amount as rendered by the panel regarding the same claim or claims and such offer is not accepted by the plaintiff and if the plaintiff subsequently brings such claim or claims to trial and receives a judgment which is less than ten percent over the total settlement amount rendered by the panel for the same claim or claims, then the defendant shall be entitled to recover the actual reasonable costs and attorney fees incurred from the date of filing the action.

(2) If the plaintiff makes a formal offer to settle a claim or claims for the same total amount as rendered by the panel regarding the same claim or claims and such offer is not accepted by the defendant and if the plaintiff subsequently brings such claim or claims to trial and receives a judgment which is less than ten percent under the total settlement amount rendered by the panel for the same claim or claims, then the plaintiff shall be entitled to recover the actual reasonable costs and attorney fees incurred from the date of filing the action.

13-20-508. Authorization to charge fees - division among parties to panel proceedings. (1) The judicial department is

authorized to charge fees to cover the total direct and indirect costs of panel proceedings provided by the department and to collect such fees from the parties to such panel proceedings, as follows:

(a) Before each July 1, a uniform fee shall be established, pursuant to section 13-20-509, for each panel proceeding to be held during the following fiscal year.

(b) The plaintiff or plaintiffs shall be required to pay an aggregate fee which equals one-half of the total uniform fee to be collected for each panel proceeding, and, if applicable, the one-half portion shall be divided equally among and collected from each of the various plaintiffs.

(c) The defendant or defendants shall be required to pay an aggregate fee which equals one-half of the total uniform fee to be collected for each panel proceeding, and, if applicable, the one-half portion shall be divided equally among and collected from each of the various defendants.

13-20-509. Uniform fee established - medical malpractice panel cash fund created - moneys collected from fees credited to fund. (1) This section shall apply to all activities of the judicial department pursuant to this part 5.

(2) (a) The judicial department shall propose, as part of its annual budget request, a uniform fee to be collected for each panel proceeding to be held during the fiscal year for which the budget request applies. The uniform fee shall reflect anticipated total direct and indirect costs of the judicial department in providing panel proceedings pursuant to

this part 5 during the fiscal year for which the budget request applies.

(b) The uniform fee shall remain in effect for the fiscal year for which the budget request applies. All fees collected by the judicial department shall be transmitted to the state treasurer, who shall credit the same to the medical malpractice panel cash fund, which fund is hereby created. All moneys credited to the medical malpractice panel cash fund and all interest earned thereon shall be subject to appropriation by the general assembly to be used as provided in this section and shall not be credited or transferred to the general fund of this state or any other fund.

(c) Beginning July 1, 1986, and each July 1 thereafter, whenever moneys appropriated to the judicial department for its activities pursuant to this part 5 for the prior fiscal year are unexpended, said moneys shall be made a part of the appropriation to the judicial department for the next fiscal year, and such amount shall not be raised from fees collected by the judicial department. If a supplemental appropriation is made to the judicial department for its activities pursuant to this part 5, the fees of the judicial department, when adjusted for the fiscal year next following that in which the supplemental appropriation was made, shall be adjusted by an additional amount which is sufficient to compensate for such supplemental appropriation. Moneys appropriated to the judicial department for its activities pursuant to this part 5 in the annual general appropriation bill shall be designated

as cash funds and shall not exceed the amount anticipated to be raised from fees collected by the judicial department pursuant to section 13-20-508.

SECTION 2. Effective date - applicability. This act shall take effect July 1, 1986, and shall apply to personal injury and wrongful death claims for damages arising out of the provision of or alleged failure to provide health care filed on or after said date.

SECTION 3. 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.

BILL 26

A BILL FOR AN ACT

CONCERNING THE REPEAL OF THE "COLORADO CERTIFICATE OF PUBLIC NECESSITY ACT".

Bill Summary

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

Repeals the "Colorado Certificate of Public Necessity Act" and makes conforming amendments. Requires that proposed hospital districts comply with the "Special District Act".

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

SECTION 1. Repeal. Part 5 of article 3 of title 25, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is repealed.

SECTION 2. 10-17-105 (1) (a) and (1) (b), Colorado Revised Statutes, are amended to read:

10-17-105. Powers of health maintenance organizations. (1) (a) The purchase, lease, construction, renovation, operation, and maintenance of hospitals, medical facilities, nursing care and intermediate care facilities, and other

institutions of like nature, their ancillary equipment, and such property as may reasonably be required for its administrative offices or for such other purposes as may be necessary to accomplish the business of the organization; ~~subject to the requirements of part 5 of article 3 of title 25, C.R.S. 1973;~~

(b) The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities, hospitals, nursing care and intermediate care facilities, and other institutions of a like nature, ~~subject to the requirements of part 5 of article 3 of title 25, C.R.S. 1973,~~ providing health care services to enrollees;

SECTION 3. Part 1 of article 1 of title 25, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

25-1-108.1. Nonparticipation in federal program on capital expenditures. Notwithstanding the provisions of section 25-1-108 (1) (f) or any other provision of law, the state of Colorado shall not participate in the federal program established in section 1122 of the "Social Security Amendments of 1972", P.L. 92-603, 42 U.S.C. 1320a-1.

SECTION 4. 25-1-120 (8), Colorado Revised Statutes, 1982 Repl. Vol., is amended to read:

25-1-120. Nursing and intermediate care facilities - rights of patients. (8) A patient who is eligible to receive

medicaid benefits pursuant to article 4 of title 26, C.R.S., ~~1973~~; and who qualifies for skilled or intermediate nursing care shall have the right to select any skilled or intermediate nursing care facility certified by the department of health under Title XIX of the FEDERAL "Social Security Act", AS AMENDED, as a provider of medicaid services and licensed by the department pursuant to article 3 of this title where space is available, and the department of social services shall reimburse the selected facility for services pursuant to section 26-4-110 (5), C.R.S., ~~1973~~; unless such nursing care facility ~~shall have been notified~~ HAS BEEN DENIED PARTICIPATION IN A MEDICAL ASSISTANCE PROGRAM by the department of social services at the time of ~~or prior to action~~ on its INITIAL application for SUCH PARTICIPATION. ~~certificate of public necessity that it may not qualify as a provider of medicaid services.~~

SECTION 5. 25-3-401 (2), Colorado Revised Statutes, 1982 Repl. Vol., is amended to read:

25-3-401. Department of health to administer plan. (2) The state plan established under subsection (1) of this section shall provide for adequate hospital facilities for the people residing in the state, without discrimination on account of race, creed, or color, and shall provide for adequate hospital facilities for persons unable to pay therefor. The department of health shall ~~after consultation with the Colorado health facilities review council established in section 25-3-504~~; provide minimum standards for the

maintenance and operation of hospitals which receive federal aid under this part 4, and compliance with such standards shall be required in the case of hospitals which have received federal aid under the provisions of said federal acts, or any amendments thereto.

SECTION 6. 32-1-202 (4), Colorado Revised Statutes, as amended, is amended to read:

32-1-202. Filing of service plan required - report of filing - contents - fee. (4) In the case of a proposed hospital district, ~~submission--to--the---board---of---county commissioners--by~~ the petitioners ~~of-a-certified-copy-of-an approved-certificate-of-public-necessity-issued-by-the--health facilities--review--council--of-the-department-of-health~~ shall ~~constitute-compliance~~ COMPLY with THE FILING REQUIREMENTS OF subsection (2) of this section.

SECTION 7. 32-1-203 (5), Colorado Revised Statutes, as amended, is amended to read:

32-1-203. Action on service plan - criteria. (5) In the case of a proposed hospital district, ~~submission-to-the board--of--county--commissioners--by~~ the petitioners ~~of---a certified--copy-of-an-approved-certificate-of-public-necessity issued--by--the--health--facilities--review--council--of---the department--of--health~~ shall ~~constitute-compliance~~ COMPLY with THE REQUIREMENTS OF subsections (2) and (2.5) of this section.

SECTION 8. 32-1-204.5 (2), Colorado Revised Statutes, as amended, is amended to read:

32-1-204.5. Approval by municipality. (2) In the case

of a proposed hospital district, ~~submission-to-the-governing body-of-the-municipality-of-a-certified-copy--of--an--approved certificate---of---public---necessity--issued--by--the--health facilities-review-council-of--the--department--of--health~~ THE PROPOSAL shall ~~constitute--compliance--with~~ CONFORM TO the requirements of sections 32-1-202 (2) and 32-1-203 (2) and (2.5) as required by subsection (1) of this section.

SECTION 9. 32-1-207 (4), Colorado Revised Statutes, as amended, is amended to read:

32-1-207. Compliance - modification - enforcement. (4) In the case of a hospital district, a change in service by the district ~~shall--not--be--deemed--material--unless--such change--would--require-the-district-to-obtain-a-certificate-of public-necessity-from-the-health-facilities-review-council--of the-department-of-health:--A-hospital-district~~ shall be ~~exempt from~~ SUBJECT TO THE CRITERIA FOR MATERIAL CHANGE SPECIFIED IN SUBSECTION (2) AND paragraphs (b) and (c) of subsection (3) of this section.

SECTION 10. Effective date. This act shall take effect October 1, 1986.

SECTION 11. 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.

BILL 27

A BILL FOR AN ACT

CONCERNING THE FREEDOM OF PHYSICIANS TO PRACTICE MEDICINE, AND, IN RELATION THERETO, EXPANDING THE RIGHTS OF PHYSICIANS TO WORK FOR EMPLOYERS AND TREAT PATIENTS.

Bill Summary

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

Amends the definition of "unprofessional conduct" in the "Colorado Medical Practice Act" to permit licensed physicians: (1) To be employed by hospitals, hospital-owned or hospital-related corporations, and health maintenance organizations, and establishes conditions for such employment; (2) To work for partnerships or associations, the majority of whose partners or associates hold a license to practice medicine in this state; and (3) To examine and treat the dependents of the employees of persons, partnerships, associations, or corporations employing such physicians.

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

SECTION 1. 12-36-117 (1) (m), Colorado Revised Statutes, 1985 Repl. Vol., is amended to read:

12-36-117. Unprofessional conduct. (1) (m) EXCEPT AS PROVIDED IN SECTION 12-36-117.5, practicing medicine as the partner, agent, or employee of, or in joint adventure with,

any person who does not hold a license to practice medicine within this state, or practicing medicine as an employee of, or in joint adventure with, any partnership or association ~~any~~ THE MAJORITY of whose partners or associates do not hold a license to practice medicine within this state, or practicing medicine as an employee of or in joint adventure with any corporation other than a professional service corporation for the practice of medicine as defined in section 12-36-134. Any licensee holding a license to practice medicine in this state may accept employment from any person, partnership, association, or corporation to examine and treat the employees of such person, partnership, association, or corporation OR THE DEPENDENTS OF SUCH EMPLOYEES.

SECTION 2. Article 36 of title 12, Colorado Revised Statutes, 1985 Repl. Vol., is amended BY THE ADDITION OF A NEW SECTION to read:

12-36-117.5. Employment. (1) Any other provision of law to the contrary notwithstanding, a physician licensed to practice medicine in this state may be employed by a hospital licensed or certified to operate within this state, by a hospital-owned or hospital-related corporation, or by a health maintenance organization authorized to conduct business in accordance with the provision of article 17 of title 10, C.R.S., under such conditions as are established in this article.

(2) No physician practicing medicine under the provisions of this article shall perform or be required to

perform any act which constitutes unprofessional conduct.

(3) Any physician practicing medicine under the provisions of this article shall practice according to accepted standards of medical care, shall be subject to such professional review as established under the provisions of article 43.5 of this title, and shall be subject to the jurisdiction in this article irrespective of employment, business, or other practice arrangements.

(4) The board may, in its discretion, under the authority of this article and article 43.5 of this title, establish such clinical conditions and standards for the practice of medicine in an employment arrangement as necessary to protect the public. To this effect, the powers of the board are to be liberally construed.

(5) Nothing in this article shall be construed to make invalid the provisions of section 8-2-113 (3), C.R.S.

SECTION 3. 12-36-134 (7), Colorado Revised Statutes, 1985 Repl. Vol., is amended to read:

12-36-134. Professional service corporations for the practice of medicine. (7) Except as provided in this ~~section~~ ARTICLE, corporations shall not practice medicine.

SECTION 4. 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.

BILL 28

A BILL FOR AN ACT

CONCERNING REQUIREMENTS FOR THE ISSUANCE OF A MARRIAGE LICENSE.

Bill Summary

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

Repeals the requirement that before a marriage license will be issued a female applicant under the age of forty-five must present a certificate from a physician stating that the applicant has been given a medical examination and serological tests for rubella immunity and Rh type.

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

SECTION 1. 14-2-106 (1) (a) (II), Colorado Revised Statutes, is amended to read:

14-2-106. License to marry. (1) (a) (II) Satisfactory proof that the marriage is not prohibited, as provided in section 14-2-110. and

SECTION 2. Repeal 14-2-106 (1) (a) (III) and (2), Colorado Revised Statutes, as amended, are repealed.

SECTION 3. 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.

BILL 29

HOUSE CONCURRENT RESOLUTION NO.

SUBMITTING TO THE REGISTERED ELECTORS OF THE STATE OF COLORADO AN AMENDMENT TO SECTION 3 OF ARTICLE XXIV OF THE CONSTITUTION OF THE STATE OF COLORADO, CHANGING THE MINIMUM AGE OF ELIGIBILITY FOR PUBLIC ASSISTANCE IN THE FORM OF OLD AGE PENSIONS TO AGE SIXTY-FIVE.

Resolution Summary

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

Amends section 3 of article XXIV of the state constitution to change the minimum age of eligibility for state public assistance in the form of old age pensions from age sixty to age sixty-five.

Be It Resolved by the House of Representatives of the Fifty-fifth General Assembly of the State of Colorado, the Senate concurring herein:

SECTION 1. At the next general election for members of the general assembly, there shall be submitted to the registered electors of the state of Colorado, for their

approval or rejection, the following amendment to the constitution of the state of Colorado, to wit:

Section 3 of article XXIV of the constitution of the state of Colorado is amended to read:

Section 3. Persons entitled to receive pensions. ~~From and after January 1, 1957~~ ON OR AFTER JANUARY 1, 1987, every citizen of the United States who has been a resident of the state of Colorado for such period as the general assembly may determine, who has attained the age of ~~sixty~~ SIXTY-FIVE years or more, and who qualifies under the laws of Colorado to receive a pension, shall be entitled to receive the same; ~~provided, however,~~ EXCEPT that no person otherwise qualified shall be denied a pension by reason of the fact that he is the owner of real estate occupied by him as a residence; nor for the reason that relatives may be financially able to contribute to his support and maintenance; nor shall any person be denied a pension for the reason that he owns personal property which by law is exempt from execution or attachment; nor shall any person be required, in order to receive a pension, to repay, or promise to repay, the state of Colorado any money paid to him as an old age pension. ON OR AFTER JANUARY 1, 1987, NO FURTHER APPLICATIONS WILL BE ACCEPTED FOR OLD AGE PENSIONS FROM PERSONS UNDER THE AGE OF SIXTY-FIVE.

SECTION 2. Each elector voting at said election and desirous of voting for or against said amendment shall cast his vote as provided by law either "Yes" or "No" on the

proposition: "An amendment to section 3 of article XXIV of the constitution of the state of Colorado, changing the minimum age of eligibility for public assistance in the form of old age pensions to age sixty-five."

SECTION 3. The votes cast for the adoption or rejection of said amendment shall be canvassed and the result determined in the manner provided by law for the canvassing of votes for representatives in Congress, and if a majority of the electors voting on the question shall have voted "Yes", the said amendment shall become a part of the state constitution.

BILL 30

A BILL FOR AN ACT

CONCERNING VENDOR PARTICIPATION IN PREPAID CAPITATED PROGRAMS UNDER THE "COLORADO MEDICAL ASSISTANCE ACT".

Bill Summary

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

Authorizes the state department of social services to enter into negotiated contracts with vendors to provide medical services under the "Colorado Medical Assistance Act" based on a fixed rate of reimbursement per recipient. Requires the executive director of the department to determine that a contract will reduce the cost of providing medical benefits before awarding such contract. Exempts vendors of prescription drugs from such provisions. Requires the department to make good faith efforts to obtain a waiver from the federal "freedom of choice" statutes which would prohibit the implementation of the contracting authority. Authorizes the executive director to exempt the soliciting and awarding of such contracts from the "Procurement Code", with the exception of the appeals provisions.

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

SECTION 1. 26-4-110, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS to read:

26-4-110. Vendors - payments - rules. (9) (a) As used

in this subsection (9), "capitated" means a mode of payment by which a vendor which meets the same financial solvency, audit, quality assurance, deceptive marketing practices, and actuarial requirements as a vendor licensed pursuant to title 10, C.R.S., directly delivers or arranges for delivery of medical care benefits for the duration of a contract with the state department based on a fixed rate of reimbursement per recipient.

(b) (I) To provide medical benefits under this article on a capitated basis and subject to the condition imposed in subparagraph (II) of this paragraph (b), the state department is authorized to solicit negotiated contracts with vendors based upon the requirements of this subsection (9). The state department may contract with one or more vendors concerning the same medical services in a single geographic area.

(II) The state department may award a contract to one or more vendors pursuant to subparagraph (I) of this paragraph (b) when the executive director determines that such contract will reduce the costs of providing medical benefits under this article.

(III) This paragraph (b) shall not apply to an independent provider of prescription drugs otherwise eligible as a vendor under this article if such independent provider is not associated with or providing drugs to a vendor which is reimbursed on a capitated basis.

(c) The state department may promulgate rules and regulations to provide for the implementation and

administration of this subsection (9).

(d) The state department shall make good faith efforts to obtain a waiver from the requirements of Title XIX which would otherwise prohibit the implementation of this subsection (9). Such a waiver shall be obtained from the federal department of health and human services. Without such a waiver, then, to the extent that Title XIX prohibits it, the state department shall not act to implement or administer this subsection (9).

(10) The executive director is authorized to designate in writing that the process of soliciting and awarding any contract pursuant to this section be exempted from the provisions of the "Procurement Code", articles 101 to 112 of title 24, C.R.S., with the exception of part 2 of article 109 of title 24, C.R.S., which shall continue to apply in such a situation.

SECTION 2. 24-101-105 (1), Colorado Revised Statutes, 1982 Repl. Vol., is amended to read:

24-101-105. Application of this code. (1) This code shall apply to all publicly funded contracts entered into by all governmental bodies of the executive branch of this state; except that this code shall not apply to the procurement of bridge and highway construction. Except as provided in section 24-111-103, it shall also apply to contracts funded in whole or in part with federal assistance moneys. However, this code shall not apply to the awarding of either grants or contracts between the state and its political subdivisions or

other governments, except as provided in article 110 of this title. IN ADDITION, WITH THE EXCEPTION OF PART 2 OF ARTICLE 109 OF THIS TITLE, THIS CODE SHALL NOT APPLY TO THE SOLICITATION OR AWARDING OF CONTRACTS TO PROVIDE MEDICAL BENEFITS UNDER THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLE 4 OF TITLE 26, C.R.S., WHEN THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF SOCIAL SERVICES DESIGNATES PURSUANT TO SECTION 26-4-110 (10), C.R.S., THAT THIS CODE SHALL NOT APPLY. ~~It~~ THIS CODE shall apply to the transfer or disposal of state supplies. Except for the provisions of article 109 of this title, this code shall not apply to the procurement of public printing, as defined in section 24-70-201. This code shall not apply to the procurement of professional services, as defined in section 24-30-1402. Upon the request of a governmental body purchasing items for resale to the public, the state purchasing director or the head of a purchasing agency may, by written determination, provide that this code shall not apply to items acquired for such resale. Nothing in this code or in rules promulgated under this code shall prevent any governmental body or political subdivision from complying with the terms and conditions of any grant, gift, bequest, or cooperative agreement.

SECTION 3. 24-103-201 (1), Colorado Revised Statutes, 1982 Repl. Vol., is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

24-103-201. Methods of source selection. (1) (f) Section 26-4-110 (9) and (10), C.R.S., concerning the

soliciting and awarding of contracts pursuant to the "Colorado Medical Assistance Act", article 4 of title 26, C.R.S., in designated situations.

SECTION 4. 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.

BILL 31

A BILL FOR AN ACT

CONCERNING THE CONSIDERATION OF THE VOLUNTARY ASSIGNMENT OR TRANSFER OF PROPERTY IN DETERMINING ELIGIBILITY FOR PUBLIC ASSISTANCE.

Bill Summary

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

Eliminates an exception to the general prohibition on the assignment or transfer of property without fair and valuable consideration in determining eligibility for public assistance. That is, repeals a provision which allows for such an assignment or transfer if its primary purpose "is not to acquire moneys or profit but is for some other legitimate reason such as estate planning".

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

SECTION 1. Repeal. 26-2-111 (1) (c) (I) (B), Colorado Revised Statutes, 1982 Repl. Vol., is repealed.

SECTION 2. 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.

LEGISLATIVE COUNCIL

COMMITTEE ON SENTENCING AND CRIMINAL JUSTICE

Members of the Committee

Rep. Don Mielke,
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SUMMARY OF RECOMMENDATIONS

The Committee on Sentencing and Criminal Justice was directed to undertake a comprehensive study of the structure of sentencing of felons and the criminal justice system. The specific elements of the charge included the following:

(a) Evaluating the state's current determinate sentencing system;

(b) Analyzing the pattern of determinate sentences given for specific felonies, including an examination of sentences given for crimes of violence;

(c) Investigating the use of felony fines as a method of punishing convicted offenders and as an alternative to incarceration;

(d) Analyzing the impact of increasing time served by class 1 felons before becoming eligible for parole;

(e) Examining the feasibility and the impact of increasing the number of felony classifications;

(f) Examining the use of plea agreements and analyzing the impact of prohibiting plea agreements in cases where the charge includes a crime of violence;

(g) Examining the impact of the vesting or nonvesting of good time on sentence lengths and the administration of the corrections system to determine when and if good time should vest, including the use of earned time and the availability of inmate work programs;

(h) Defining the purpose of parole and the role of the parole board within the criminal justice system, including the amount of discretion the board should retain in regard to determining release dates; and

(i) Any other aspect of the sentencing structure and the criminal justice system deemed necessary.

Because of the amount of substantive legislation enacted during the 1985 session relating to the sentencing structure and the criminal justice system, the committee focused attention on the affect of this newly enacted legislation on the judiciary and the Department of Corrections. In addition, the committee solicited views from actors in the criminal justice system to determine the need for new legislation or for improvement or refinement in current law.

During the course of the interim, the committee heard testimony from many individuals involved in the criminal justice system, including members of the judiciary, the Department of Corrections, the Division of Criminal Justice, the State Board of Parole, prosecutors, public defenders, persons associated with community

corrections, and interested citizens. As a result of its deliberations, the committee recommends 13 bills for legislative consideration during the 1986 session. A summary of the committee's recommendations follows.

Concerning Alcohol- and Drug-Related Traffic Offenses -- Bill 32

Bill 32 amends numerous provisions of the law with respect to alcohol- and drug-related traffic offenses, concentrating primarily on driving with excessive alcoholic content, revocation of drivers' licenses, and the administration of chemical tests. A summary of the major provisions of the bill follows.

-- The bill changes the requirements for a per se offense, lowering the amount of blood alcohol content (BAC) for this offense from 0.15 to 0.10. The bill also allows a chemical analysis of blood or breath to be performed at the time of the commission of the alleged offense or within two hours thereafter.

-- Law enforcement officials are vested with the authority to determine the type of chemical analysis to be used to determine alcohol or drug content and when such a test should be performed. The bill deletes language specifying that a test only be given after an arrest for a misdemeanor offense arising from the operation of the vehicle. A law enforcement officer may now administer a test if he has reasonable grounds to believe that a person is driving under the influence of alcohol.

-- Failure of a person to cooperate in submitting to testing is considered a refusal to submit to testing.

-- The bill establishes a new administrative review process designed to ensure an opportunity for administrative review prior to the effective date of a license revocation. The administrative review is available upon request to drivers who have received a notice of license revocation. The period between the issuance of notice of revocation and the effective date of the revocation is lengthened from seven to fifteen days to allow for the administrative review.

-- The Department of Revenue's initial determination as to whether a driver's license is revoked is to be based solely upon the report of the law enforcement officer. During the administrative review, the department is to consider sworn statements and evidence submitted by the driver as well as the officer's report.

-- A request for hearing or a petition for judicial review concerning a license revocation will not operate to stay a revocation.

-- In order to have driving privileges restored following a license revocation, an individual must present evidence satisfactory to

the department that the individual's problem with alcohol use is under control. This is a change from current law which requires the Department of Revenue to conduct an investigation to determine that it is safe to grant a driver's license.

-- Although the law prohibits physical restraint to obtain specimens for testing, a person could be physically restrained for the purpose of testing if a law enforcement officer has reasonable grounds to believe that the person has committed vehicular homicide or vehicular assault.

-- Every person who is convicted of, pleads guilty to, or receives a deferred sentence for a per se offense is required to pay $50 to the law enforcement assistance fund for the prevention of drunken driving and $10 to the county treasury of the county in which the conviction occurred.

Compilation of Sentences Imposed by District Court Judges -- Bill 33

Bill 33 directs the clerk of the district court in each judicial district to make available a compilation of the actual sentences imposed by each judge in the district. The clerk shall make the compilation available weekly and it shall include the name of the judge, the name of the offender and a description of the felony for which he was convicted, and the sentence imposed by the judge.

Mandatory Sentences for Violent Crimes -- Bill 34

Bill 34 amends the laws describing specific crimes to require sentencing in accordance with the provisions of the crime of violence statute (section 16-11-309, C.R.S.). The offenses for which the crime of violence statute has been cross-referenced include: first and second degree assault, assault on the elderly or the handicapped, second degree kidnapping, third degree sexual assault, sexual assault on a child, and aggravated robbery. Bill 34 is recommended to address issues raised by the Court of Appeals in its decision in People v. William A. Montoya. It is designed to insure that defendants convicted of a crime involving the use of a deadly weapon or the infliction of serious bodily injury to the victim, or of a sexual offense involving the use of force, intimidation, or threat against the victim is eligible for an enhanced sentence.

Offender-Based Tracking System -- Bill 35

Bill 35 requires the reporting of specified information concerning an offender at the different stages of an offender's progress through the criminal justice system. The information to be reported includes the offender's full name and any aliases, date of birth, all dates of arrests, all arrest and offense numbers assigned by the law enforcement agency, the district attorney's case number,

the district court's case number, and the Colorado Bureau of Investigation's identification number. The bill also requires the court to order and cause to be documented the fingerprinting of any offender who has not been arrested or fingerprinted for the charge pending before the court. All such fingerprints are to be forwarded to the Colorado Bureau of Investigation upon conviction of the offender.

Risk Assessment Guidelines for Parole -- Bill 36

Bill 36 sets forth objective guidelines for the State Board of Parole to consider in determining whether or not a person should be released from institutional custody. The parole guidelines in Bill 36 are modeled after the 1984 version of the Iowa risk assessment scale. Categories are established for general risk and violent risk, and an offender's score is computed based on prior violence scoring, street time scoring, criminal history scoring, current escape scoring, and substance abuse scoring. The bill directs the Division of Criminal Justice to monitor the parole board's use of the parole criteria, validate the criteria on Colorado inmates, and report to the General Assembly by January 1, 1987 concerning the impact of the use of the criteria on parole rates and risk to society.

Establishment of Intensive Supervision Probation Programs -- Bill 37

Bill 37 provides the Judicial Department with the authority to establish programs in judicial districts for the intensive supervision of probationers. Intensive supervision is designed to provide an alternative to the sentencing of selected offenders to the Department of Corrections. Offenders who might otherwise be committed to a DOC facility are eligible for an intensive supervision program if the court determines that the offender is not a threat to society. The Judicial Department is vested with the power to establish and enforce standards and criteria for the administration of the programs.

State Services for Defendants Charged with Traffic Violations -- Bill 38

Bill 38 adds traffic violations to the list of offenses for which the state is not required to provide legal representation and supporting services if the prosecuting attorney stipulates that he will not seek incarceration as part of the penalty upon conviction.

Clarification of the Elements of the Class 2 Traffic Offense of Violating a Speed Limit -- Bill 39

Bill 39 clarifies that speeding twenty miles per hour or more over the prima facie speed limit is a class 2 traffic offense. Current law limits the class 2 traffic offense solely to speeding twenty miles per hour over the speed limit.

Release from Commitment after Verdict of Not Guilty by Reason of Insanity or Impaired Mental Condition -- Bill 40

Bill 40 addresses procedural aspects of a request for a release hearing when a defendant has been committed after a verdict of not guilty by reason of insanity or impaired mental condition. The bill stipulates that when a defendant requests a release hearing and none of the required reports indicate the defendant is eligible for release, the defendant must submit evidence by a medical expert in mental disorders indicating eligibility for release. Current law does not specify that such proof be submitted by such an expert.

The need for this amendment to current law was brought to the committee's attention as a result of the Colorado Court of Appeals' decision in People of the State of Colorado v. Darrell Lee Howell, 701 P. 2d 131 (March 21, 1985). Defendant Howell was committed to the Colorado State Hospital after he was found not guilty by reason of insanity in two separate homicide cases in 1971 and 1972. In both 1977 and 1980, release hearings were conducted and it was determined by a jury that Howell was not eligible for release.

In 1981, Howell filed another motion for a release hearing before a jury. The People moved to dismiss and the motion was granted by the trial court. Defendant Howell appealed the dismissal of his motion for a release hearing contending that the trial court erroneously interpreted section 16-8-115 (2), C.R.S., which provided in part:

> If the question of defendant's eligibility for release is contested, the court shall order a release examination of the defendant when a current one has not already been furnished or when either the prosecution or defense moves for an examination of defendant at a different institution or by different experts. The court may order any additional or supplemental examination, investigation, or study which it deems necessary to a proper consideration and determination of the question of eligibility for release. The court shall set the matter for release hearing after it has received all of the reports which it has ordered under this section. When none of said reports indicate the defendant is eligible for release, the defendant's request for release hearing may be denied by the court if the defendant is unable to show by way of an offer of proof any other evidence that would indicate that he is eligible for release. The release hearing shall be to the court or on demand by the defendant to a jury of not to exceed six persons... (emphasis added).

Because the report of the psychiatrist appointed by the trial court was not favorable to the release of the defendant, the trial court required the defendant to make an offer of proof. The resultant offer of proof included lay testimony from a number of witnesses, including the defendant and his wife, indicating the defendant was

eligible for release. It also included certain favorable aspects of the report filed by the court-appointed psychiatrist, even though the report's conclusion did not favor release.

The appellate court concluded that the trial court construed the statutory language "any other evidence" to mean that a defendant must include in his offer of proof evidence by a medical expert in mental disorders to rebut the report filed by the court-appointed psychiatrist that indicated the defendant is not eligible for release. The Court of Appeals disagreed, stating:

> The trial court's interpretation of the phrase "any other evidence" in section 16-8-115 (2) is erroneous because it ignores the plain meaning of the words and imposes requirements which are clearly not implied by any of the language of the statute. Where the language of a statute is plain and its meaning is clear, the statute must be enforced as written... Thus, here, "any other evidence" means just that and does not mean, for example, "any expert testimony."

Placement of Offenders in Community Correctional Facilities -- Bill 41

Bill 41 makes five changes to the community corrections statute:

1) it deletes references to "violent" or "nonviolent" offenders;
2) it provides that persons whose paroles have been revoked may be placed in community correctional facilities;
3) it allows corrections boards to screen offenders transferred to this state from another state before their placement in a community correctional facility;
4) it permits a unit of local government or corrections board to accept, reject, or reject after acceptance the placement of an out-of-state offender in a facility within its territorial jurisdiction; and
5) it authorizes the use of objective risk assessment guidelines in the screening process.

Elements of the Offense of Manufacturing, Selling, or Delivering Drug Paraphernalia -- Bill 42

Bill 42 states that a person commits a class 2 misdemeanor if he manufactures, sells, or delivers equipment or materials under circumstances where he should have a reasonable belief that such equipment or materials will be used as drug paraphernalia. The "reasonable belief" standard is added to the current standard of "intent" because it provides an alternative avenue for prosecution when intent can not be proved.

Report on Double Occupancy of Prison Cells

The committee requested from the Department of Corrections a plan for a program of double-bunking in state correctional facilities. The committee requested that the report be submitted to the General Assembly by February 25, 1986 so that it can be reviewed by the appropriate committees of reference during the 1986 legislative session.

Committee Bills Not Approved By Legislative Council

Although the two bills summarized below are recommendations of the Committee on Sentencing and Criminal Justice, the Legislative Council rejected these bills at its meeting on October 15, 1985. Copies of these bills are on file in the Legislative Council office.

Jurisdiction of Colorado Appellate Courts

Through this proposed bill the initial jurisdiction of the Court of Appeals is expanded to encompass appeals of cases in which the constitutionality of a statute, a municipal charter provision, or an ordinance is in question. The jurisdiction of the Court of Appeals is limited insofar as the court will no longer be required to hear appeals in cases involving the suspension, cancellation, or revocation of drivers' licenses or cases in which the decision of an administrative agency is subject to judicial review. In these cases, review beyond the district court will be in the Supreme Court by petition for certiorari.

Privitization of Correctional Services and Facilities

This proposed bill authorizes the executive director of the Department of Corrections to contract for correctional facilities and services, including detention, incarceration, education, employment, treatment, rehabilitation, conservation camps, and work programs. The executive director may also issue an invitation for bids for the private construction and private management of a correctional facility. The bill exempts contractual institutions and their employees from liability for: (1) an injury caused by an escaping or escaped prisoner, and (2) an injury caused by a prisoner to any other prisoner.

COMMITTEE ACTIVITIES

During the 1985 legislative session numerous bills were enacted amending the state's criminal code. Testimony before the committee indicated that several of these bills will impact the criminal justice system in the near future by placing a severe strain on correctional resources. The committee identified as one of its primary goals a study of methods which could act to reduce pressures on the prison population yet not increase the overall risk to the health and welfare of society.

Another issue identified by the committee as important to the effective operation of the criminal justice system was the viability of the crime of violence sentencing statute. A recent Colorado court decision has raised questions about its use in certain instances. Finally, committee members expressed an interest in ensuring the most cost-effective and efficient operation of the system with available financial resources.

Criminal Justice System Issues

1985 Legislation

A major component of the 1985 legislative package affecting the criminal code, House Bill 1320 revised the felony presumptive sentencing ranges. The new scheme applies to offenses committed on or after July 1, 1985. Although the minimum sentence of the ranges remained the same, the bill doubled the maximum penalty in each felony class. In addition, a presumptive range of fines was established for four of the five felony classes. A fine may be levied in lieu of or in addition to imprisonment. It can not be substituted for imprisonment, however, when a person has been convicted of a crime of violence. The new presumptive ranges for sentences and fines are depicted in the chart below.

PRESUMPTIVE RANGES FOR SENTENCES AND FINES
EFFECTIVE JULY 1, 1985

Felony Class	Minimum Sentence	Maximum Sentence	Minimum Fine	Maximum Fine
1	life imprisonment	death	no fine	no fine
2	8 years	24 years	$5,000	$1 million
3	4 years	16 years	$3,000	$750,000
4	2 years	8 years	$2,000	$500,000
5	1 year	4 years	$1,000	$100,000

Other major changes affecting sentencing laws on July 1, 1985 include the following:

(1) A person convicted of two separate crimes of violence arising out of the same incident is to be sentenced to consecutive, rather than concurrent, sentences;

(2) Life imprisonment is defined as imprisonment for forty years without the possibility of parole (prior to July 1, 1985, a person could be eligible for parole after twenty years); and

(3) Good time, which accrues at the rate of fifteen days per month, is no longer vested and may be withdrawn or deducted by the Department of Corrections.

Amendments to the parole statutes are also expected to impact the availability of space in state correctional facilities. House Bill 1320 vested with the state Board of Parole, in conjunction with the Department of Corrections, the discretionary authority to determine whether to grant parole and, if granted, its length and the conditions under which it is granted. An offender is eligible for consideration of parole once his sentence has been served less any good time or earned time. Prior to July 1, 1985, the law directed that an offender be released outright or under parole supervision once his sentence had been served less good time and earned time. The maximum period of parole supervision has been increased from three to five years.

Prison Population Projections

As a result of the new legislation, the state Division of Criminal Justice developed prison population projections through fiscal year 1994-95. According to the division, a doubling of the size of the prison population can be expected in ten years. A chart illustrating these projections, as well as the state's prison needs based on the projections, can be found on page 175. The division's projections are based on an increased incarceration period for offenders and not on a substantial increase in the rate of offenders admitted annually. It is also being assumed that: (1) judges will continue sentencing to the midpoint of the presumptive range; and (2) the parole board will use its discretionary powers and increase the time served by offenders on an average of twenty-five percent.

Statistics presented by both the Department of Corrections and the Judicial Department indicate that judges are currently sentencing above the midpoint for crimes committed prior to July 1, 1985. The Department of Corrections stated its belief that the division's estimates may be conservative and potential overcrowding problems may be more severe. Overcrowded prison conditions lead to increased incidents of rule infraction and violence. Stress levels among both inmates and staff increase.

PROJECTED PRISON CAPACITY 1/
1985 - 1995

Fiscal Year	85/86	86/87	87/88	88/89	89/90	90/91	91/92	92/93	93/94	94/95
BEDS NEEDED										
New 2/	50	668	1582	1900	2451	2802	3038	3202	3366	3516
Old 3/	3246	3246	3246	3246	3246	3246	3246	3246	3246	3246
Jail	150	100	100	100	100	100	100	100	100	100
TOTAL	3446	4014	4928	5346	5797	6148	6384	6548	6712	6862
AVAILABLE 4/										
Permanent 5/	2672	2672	2672	2672	2672	2672	2672	2672	2672	2672
Modulars	359	359	359	359	359	359	359	359	359	359
Cellhouses 1&7 6/		261	261	261	261	261	261	261	261	261
Ordway			500	500	500	500	500	500	500	500
New Diagnostic 7/				250	250	250	250	250	250	250
Comm Corr	285	285	285	285	285	285	285	285	285	285
Intensive Supervision	40	40	40	40	40	40	40	40	40	40
TOTAL	3356	3617	4117	4367	4367	4367	4367	4367	4367	4367
NET NEEDED (JAIL BACKLOG)	90	397	811	979	1430	1781	2017	2181	2345	2495

1. Medium projection
2. H.B. 1320 and projected admission increases
3. DOC 7/8/85 inmate population summary
4. Beds now in place or legislatively authorized
5. All current DOC beds less 225 community corrections, 40 intensive supervision, and 309 modulars
6. Eliminates double-bunking
7. Assumes old diagnostic beds continue in use

Division of Criminal Justice 1985
(Updated after passage of House Bill 1307)

Based on the testimony presented regarding an impending prison population crisis, the committee took action in August urging the General Assembly to take immediate steps to provide increased prison space. The recommendations of the committee included:

-- the expansion of the proposed prison in Ordway from 250 to 500 beds;

-- a study of the Shadow Mountain correctional facility with a view toward the expansion of the facility;

-- a study of the feasibility of adding a women's prison to the Denver diagnostic center authorized by Senate Bill 193; and

-- to provide revenues for the construction of new prison facilities, an eight-cent increase in the state excise tax on the sale of cigarettes should the federal government allow its eight-cent tax to expire.

During the latter part of the 1985 session, the General Assembly did act to increase the space at Ordway to 500 beds through the adoption of House Bill 1307. (This change has been incorporated into the prison population projections on page 175.) In addition, the legislature removed the 150-bed cap at the proposed Denver diagnostic center and authorized a comprehensive study of prison construction needs with specific recommendations for the expanded use of community corrections and for the expansion of the Shadow Mountain facility.

The interim committee undertook as its responsibility the evaluation of mechanisms, other than those related to capital construction, to alleviate the potential overcrowding problem. Uppermost in the committee's thinking was that there be no reduction in public safety. The committee endeavored to ensure that violent and repeat offenders are incarcerated for a term corresponding to the seriousness of the offense committed. To that end, the committee focused attention on sentencing guidelines, risk assessment for parole, intensive supervision for probation, community correctional programs, and double-bunking of prison facilities.

Sentencing Guidelines

Committee deliberations with respect to sentencing guidelines included discussions on guidelines implemented on a statewide level as well as guidelines developed at the judicial district level. Sentencing guidelines evolved to achieve consistency and uniformity in sentencing practices among various courts and jurisdictions. In recent years the concept of guidelines has been expanded to take into consideration the limited resources of correctional systems and the desire of state legislatures to ensure that sentence ranges correspond to the seriousness of the offense.

Statewide guidelines. The committee heard testimony from the National Conference of State Legislatures about other states that have adopted sentencing guidelines legislation. Florida, Minnesota, Pennsylvania, and Washington are currently sentencing offenders under sentencing guidelines legislation, while four other states -- Maine, New York, South Carolina, and Texas -- are in the process of developing guidelines for legislative consideration. Testimony indicated common characteristics are present among existing legislatively approved sentencing guidelines:

(1) The sentencing structure is determinate rather than indeterminate.

(2) Except in Pennsylvania, the concept is based on the punishment model of justice rather than rehabilitation.

(3) A commission is established to develop, implement, and monitor the guidelines.

(4) Legislative approval is required and oversight is maintained.

(5) A chart or grid is used by the sentencing judge to determine the appropriate sentence. Sentences are based on the seriousness of the crime and the criminal history of the offender.

(6) Appellate review of sentences is the enforcement mechanism of sentencing guidelines.

(7) Parole decision-making is limited or removed.

Local guidelines. Colorado's Fourth Judicial District is involved in a pilot project, the goal of which is to reduce its contribution to prison overcrowding with no increase in public risk. To accomplish this goal, sentencing guidelines are in the development stage. As the initial step in creating comprehensive sentencing guidelines, a matrix has been developed for use in determining whether an offender should be incarcerated. The two-dimensional matrix is based on level of offense seriousness and criminal history score. In creating its matrix, the district excluded mandatory sentences and class 2 felonies. Felonies in class 3 through class 5 were divided into violent/nonviolent categories to create six levels of offense seriousness. The remaining component of the matrix, the criminal history score, considers juvenile adjudications, juvenile commitments, prior felony convictions, prior violent felony convictions, adult probation revocations, and adult parole revocations. The district is presently in the process of promulgating its actual sentencing guidelines.

Members of the judiciary were disturbed by the idea of statewide sentencing guidelines and, instead, endorsed the concept of guidelines implemented in each judicial district. Such guidelines would reflect the values and unique characteristics of the community and preserve judicial discretion. Although disparity in the length of sentences

imposed will exist with the current broad presumptive ranges, sentencing guidelines are not the solution to disparity caused by judicial discretion. If it is determined by the General Assembly that judicial discretion should be eliminated, sentence ranges should be narrowed.

Proponents of statewide sentencing guidelines contend that consistency in sentencing patterns is desirable. Offenders committing similar crimes in different regions of the state should be punished in a similar fashion. The guidelines also act as a risk assessment mechanism designed to ensure that violent offenders are incarcerated for an appropriate period of time. On the other hand, nonviolent offenders can be diverted into other, more suitable programs (i.e., community corrections and probation). Thus, strain on correctional facilities would be somewhat relieved without an increase in risk to the public.

Committee members debated the merits and drawbacks of local and statewide guidelines and decided that judicial districts could employ the use of sentencing guidelines without further statutory direction. Thus, the committee makes no recommendation with respect to sentencing guidelines.

Risk Assessment for Parole

When the state Board of Parole was vested in 1985 with the authority to determine whether an offender is released from a correctional facility, the board was provided with statutory guidelines to consider in making its decision. The new section 17-22.5-303.5, C.R.S., stated that an offender can be paroled "when it is determined that there is a strong and reasonable probability that the person will not thereafter violate the law and that his release from institutional custody is compatible with the welfare of society." The statute lists items for the parole board to consider in evaluating an application for parole. It also delineates conditions which would indicate whether the offender has a high or low risk of recidivism or violence, allowing the parole board to tailor the length and conditions of parole to the offender.

It was suggested to the committee that more objective, structured criteria would better aid the parole board as it exercises its discretionary authority. On the average, convicted offenders serve only about one-half of their court-imposed sentences. Yet pressures on the correctional system continue to increase. Risk assessment guidelines were offered as a mechanism that would relieve the strain on prison resources and still protect the public from convicted felons. These guidelines have the potential for reducing recidivism by providing extended prison terms for the high-risk offender. Individuals that are good risks can be identified and their term of incarceration reduced.

Testimony was presented to the committee on the Iowa model of offender risk assessment. The Iowa Board of Parole began formally using this "risk screening" mechanism in April, 1981, and the state has found that the total volume of violent crime charged to parolees actually dropped despite the huge increase in paroles. During the period 1981-82, Iowa increased paroles by fifty percent but experienced a thirty-five percent decrease in the rate of new violence among parolees. The scale has proven to be seventy-eight percent accurate in predicting who will reoffend.

The Iowa model of offender risk assessment, which this committee recommends through Bill 36, provides two measures of risk assessment: 1) a measure of general risk to society; and 2) a measure of the specific risk of new violence. The scoring system uses the same factors for assessing the two types of risk, but applies distinct point schedules for these two purposes.

The elements that must be considered to obtain an offender's risk assessment classification include the current offense, prior violence record, street time, criminal history, current escape record, and a history of substance abuse. The scoring system is set up to provide two intermediate assessments of risk which are called the X-score and the Y-score. The X-score is the sum of the scores from the current offense, prior violence record, and street time risk factors, while the Y-score is the sum of the scores for the criminal history, current escape record, and substance abuse factors. The Y-score and X-score are then matrixed to obtain the general and violence risk assessments. A final violence risk assessment is based on the serious offender classification.

The serious offender classification is a yes/no indicator based on the presence or absence of any one of five identifiable factors: current conviction for violent felony, current conviction for escape, prior conviction for a felony in the last five years street time, or a high prior violence or substance abuse score. If any such factor is present, the offender is classified as a serious offender, which makes the assignment of a "poor" or "very poor" violence risk rating more likely.

A representative of Colorado's Division of Criminal Justice estimated that the application of Iowa's risk assessment guidelines to Colorado's prison population could result in a release of twenty-five percent of the population without increasing the risk to society. This estimate assumes that Colorado's prison population is similar to Iowa's.

Intensive Probation Supervision

Colorado's Fourth Judicial District is currently involved in an intensive probation supervision project in conjunction with its sentencing guidelines program. The purpose of the program is to divert offenders from prison, and its design calls for intensive

monitoring based on assessed needs of offenders as well as increased surveillance. The intensive supervision program is only for those offenders who are prison-bound.

An offender is eligible for the program if he is recommended for incarceration for an offense but is eligible for probation; the offender is prison-bound because of a probation revocation; or he receives a reconsideration of sentence in accordance with Rule 35 (b), Colorado Rules of Criminal Procedure. Through the use of the pre-sentence investigation report, the sentencing matrix, and a screening procedure, the probation department makes a determination on whether the offender will successfully complete the program. Because the program accepts only offenders that are prison-bound, it would act to slow the increase in the prison population. In addition, the program's design calls for the provision of alcohol and drug abuse treatment, job skills training, mental health treatment, etc., for offenders whose criminal episodes are associated with those problems.

The program offers levels of supervision not available under normal probation. It includes strict requirements for face-to-face contact between officer and probationer, collateral contacts between the officer and another person involved with the offender, daily telephone contact, curfews, employment, community service, new offense checks, and alcohol and controlled substances treatment.

The committee recognizes the benefit of such a program and recommends Bill 37. This bill vests with the Judicial Department the authority to create intensive supervision programs in judicial districts, establish and enforce standards and criteria for the administration of such programs, and monitor the results of the program.

Community Corrections Programs and Facilities

Community corrections programs and facilities serve two groups of offenders, those being diverted from incarceration in a Department of Corrections' facility and those in transition from incarceration to release. Services are provided on both a residential and nonresidential basis.

Community corrections programs present a particularly sensitive dilemma for policymakers. While they provide a relatively inexpensive method of offender disposition, their success depends upon the receptiveness of the local communities involved.

The state Judicial Department, which administers the diversion program, reported that in fiscal years 1983 and 1984 fifty percent of the offenders were class 4 felony offenders while thirty-eight percent committed class 5 felonies. The majority of offenders placed in community corrections were unemployed, lacked a high school education, or experienced alcohol, drug, or mental health problems. Thirty-four percent had prior records of two or more felonies; forty-two percent

had one felony conviction. Yet, the department reports a sixty-eight percent successful termination rate and an employment rate of sixty-seven percent. The success of the program coupled with its inexpensiveness tends to encourage its expansion.

In looking at community corrections from another perspective, however, the program involves delicate balancing of the interests of the three branches of state government, multiple units of local government, individual communities, and private enterprise. While community corrections may be a viable, cost-effective sentencing alternative for some offenders, it will remain viable only as long as the communities involved continue to be the final decision makers in determining which offenders are appropriate for placement in their neighborhoods and who is responsible for their care and supervision. Representatives of community corrections boards stressed that placement in a corrections program is a privilege granted by the community and not a right.

Several suggestions for amendments to the community corrections law were offered for committee consideration. These suggestions, outlined briefly below, originated with the judiciary, the Judicial Department, and representatives of community corrections boards.

1. Employ the use of risk assessment guidelines to help the local boards determine, through their screening process, which offenders should be placed in community corrections programs.

2. Expand the range of and services available at community correctional facilities with a corresponding increase in financial resources.

3. Delete the ability of nongovernmental community correctional facilities and programs to reject offenders.

4. Vest with local community corrections boards the authority to screen and to reject the placement of out-of-state offenders in local facilities.

5. Remove any references to offender type from the law, allowing the local boards to determine who they will accept or reject.

6. Permit the following offenders to be eligible for placement in community corrections: selected misdemeanants (i.e., DUI), mentally ill or deficient offenders (misdemeanants or felons), physically disabled offenders, and pretrial felony defendants who cannot obtain bail release.

7. Allow persons whose parole has been revoked to be placed in community corrections.

The committee rejected item 3 because it interferes with the ability of local boards and private agencies to determine which offenders it will accept. Item 6 was rejected because of the fiscal

impact to the state; in many of the instances, the cost burden would be shifted from the counties to the state. Item 2 was not addressed by the committee. The remaining items were incorporated into the committee's recommendation, Bill 41.

Double-Bunking in Correctional Facilities

On August 7, 1985, a consent decree was entered into by representatives of the plaintiffs and defendants in the 1979 case of Ramos v. Lamm. The consent order applies only to prisoners incarcerated in Centennial, Shadow Mountain, and Colorado Territorial (including the diagnostic unit) correctional facilities. The obligations of the state under the consent order will terminate in eighteen months provided the state remains substantially in compliance therewith.

At the time the consent order was signed, double-bunking in the three monitored facilities was occurring only at Cellhouse 3 at the Colorado Territorial Correctional Facility. As soon as Cellhouses 1 and 7 at Territorial are renovated and occupied, the state must phase out and discontinue double-bunking in Cellhouse 3. Thereafter, the Department of Corrections can not double-bunk at any of the three facilities during the eighteen-month term of the consent order. With respect to the three facilities, the order also contains requirements for a grievance system, physical facilities and sanitation, safety, physical and mental health care, and programs.

The Department of Corrections presented testimony to the committee indicating that technically there is nothing in the order which prohibits double-bunking in other facilities. In fact, there are facilities in Colorado such as the modular units in which double-bunking presently exists. However, the department does not believe that double-bunking represents a viable correctional policy to solve the overcrowding problem. The department stressed the importance of acknowledging the impact of past litigation in order to reduce the likelihood of attracting continued or new court jurisdiction. Past experience has shown that double-bunking increases the probability of a law suit or crisis situation.

It was stated that most of the facilities in Colorado are neither physically constructed nor adequately equipped to provide food service for double-bunked cells. In order to feasibly double-bunk, institutions must be able to provide large cell space, adequate levels of programs and activities to enable inmates to be out of their cells, and a relatively small population. The success of double-bunking also depends upon the security level of the facility and the ability to be selective about which inmates should be double-bunked.

The Department of Corrections submitted to the committee a preliminary study on double-bunking in which it estimated that 1,259 beds could be added at a cost of $81,410,112. The study also outlined possible legal ramifications inherent in double-bunking. (A copy of

the report, "Department of Corrections Double-Bunking Preliminary Studies", is on file in the Legislative Council office.)

The committee believes that double-bunking can be a workable option for providing additional bedspace and urges the General Assembly to consider its use for prisoners and in facilities deemed appropriate. The committee realizes that the strategy of double-bunking can not be approached in an overly simplistic manner and that it involves more than just adding beds. The committee is cognizant of the importance of out-of-cell time and program involvement to avoid court scrutiny. Benefits can accrue to the state in the long term if capital construction funds are used to provide rehabilitative counseling and skills-training programs. These programs will help inmates to obtain jobs upon release, reducing the likelihood of recidivism. The committee has requested the department to submit to the General Assembly a program plan for double-bunking of state facilities by February 25, 1986.

Sentencing Under the Crime of Violence Statute

On June 27, 1985, the Colorado Court of Appeals rendered a decision in the case People of the State of Colorado v. William A. Montoya (No. 84CA0310), which could have broad implications in certain instances in which the crime of violence statute (section 16-11-309, C.R.S.) is invoked for the purpose of sentencing. (The Colorado Supreme Court granted certiorari on November 19, 1985 to review this case.)

In this case, defendant Montoya claimed that the combination of his conviction of first degree assault with mandatory sentencing for violent crimes, and the resultant mandatory sentence beyond the presumptive range, denied him equal protection of the law. A person commits the crime of assault in the first degree if, with intent to cause serious bodily injury to another person, he causes serious bodily injury to any person by means of a deadly weapon. Montoya contended that the finding under the mandatory sentencing count increased his punishment but failed to add any element not already included in the first degree assault charge.

The Court of Appeals agreed with defendant Montoya, stating that the mandatory sentencing statute for crimes of violence cannot be used if:

> ...the prosecution has limited its allegation and proof to include only use of a deadly weapon in the perpetration of the underlying offense and the offense underlying the sentence enhancement allegation is one which has as one of its essential elements "use of a deadly weapon."

Mandatory Sentences for Crimes of Violence

Section 16-11-309, C.R.S., states that any person convicted of a crime of violence shall be sentenced to a term of incarceration greater than the maximum in the presumptive range, but not more than twice the maximum term. A "crime of violence" is defined by statute and can be used to enhance the sentence of an offender if any of the following three elements are present.

1. The defendant used, or possessed and threatened the use of, a deadly weapon in any of the following situations:

   a) the commission or attempted commission of <u>any</u> crime committed against an elderly or handicapped person;

   b) the commission of the crimes of murder, first or second degree assault, kidnapping, sexual assault, robbery, first degree arson, first or second degree burglary, escape, or criminal extortion; or

   c) flight from any crime listed in (b) above.

2. The defendant inflicted serious bodily injury during the commission, attempted commission, or flight from any of the felonies listed in (b) above.

3. The defendant used threat, intimidation, or force against the victim or caused bodily injury to the victim during the commission of any unlawful sexual offense listed below:

   a) first, second, and third degree sexual assault as defined and when victim is less than fifteen years of age (section 18-3-402, 403, and 404);
   b) sexual assault on a child (section 18-3-405);
   c) aggravated incest (section 18-6-302);
   d) trafficking in children (section 18-6-402);
   e) sexual exploitation of a child (section 18-6-403);
   f) soliciting a child for prostitution (section 18-7-402);
   g) pandering of a child (section 18-7-403);
   h) keeping a place of child prostitution (section 18-7-404);
   i) pimping of a child (section 18-7-405);
   j) patronizing a prostituted child (section 18-7-406); or
   k) criminal attempt, conspiracy, or solicitation to commit any of the acts specified above.

Ramifications of Decision

The committee considered the possible ramifications of the decision on the crime of violence sentencing statute. Although the Court of Appeals' decision specified that the enhancement statute (mandatory sentencing for crimes of violence) was unconstitutional as applied to this particular defendant, it raised the question as to the

statute's validity for other violent crimes when one of the definitional components of the offense is the use of a deadly weapon. It also called into question two other elements of the violent crimes statute: 1) the infliction of serious bodily injury; and 2) the use of threat, intimidation, or force or the causing of bodily injury during an unlawful sexual offense. The committee considered whether the rationale used by the court in rendering its decision in Montoya could be extended to either of these two instances when the definition of the offense is the same as the reason for the enhanced penalty.

The committee's recommendation with respect to this issue is contained in Bill 34. The committee identified those felonies in which there was some type of reference to the same definitional elements as contained in the crime of violence statute such that the sentencing of offenders might be affected by the decision in Montoya. In order to give effect to the intent of the General Assembly when it enhanced the penalty for violent crimes by enacting section 16-11-309, C.R.S., the committee amended those specific statutes to require the court to sentence a defendant in accordance with the crime of violence statute.

Streamlining the Criminal Justice System

Committee members expressed an interest in investigating the organizational structure of the criminal justice system. With limited state funds available, the committee wanted to ensure that funds are used in the most cost-effective manner. If savings can be realized through more efficient administration of the criminal justice system, excess funds could be channeled to more functional uses, such as programs and bedspace for inmates.

Suggestions were made to consolidate the parole and probation functions, utilize diagnostic center resources as a risk assessment method to determine who should be incarcerated, and create a "cradle-to-grave" criminal justice system whereby juvenile and adult probation, corrections, parole, and diversion are contained within the same administrative unit. It was estimated that the latter option could save the state $2 million and allow one agency to set priorities for the entire system.

While the committee believes that some of the suggestions have merit, it was disappointed with the lack of information presented with respect to the current organization of the criminal justice system and options for changing that system. Thus the committee makes no recommendation for realigning the system but it encourages continued evaluation to determine if improvements can be made.

Offender-Based Tracking System

The Division of Criminal Justice testified that Colorado's criminal justice system could operate more efficiently if there was a common system identifier for each offender. Each offender traveling through the system would keep the same "identity" or number through the arrest, prosecution, and incarceration phases. It was suggested that when an offender is fingerprinted a number be assigned to those prints. That number could be used to identify the offender through every state of the process. In addition, it was proposed that a required system of entry of arrest be implemented whereby fingerprints are obtained from every person upon whom charges are filed.

In response to this testimony the committee recommends Bill 35. Although the bill does not direct that a single number be assigned to an offender, it does require a compilation of information relating to the offender. The information to be reported includes the offender's full name and any aliases, date of birth, all dates of arrest, all arrest and offense numbers assigned by a law enforcement agency, the district attorney's case number, the district court's case number, and the Colorado Bureau of Investigation's identification number. The bill also requires the transfer of fingerprints ordered by the court to the bureau upon the offender's conviction.

BILL 32

A BILL FOR AN ACT

1 CONCERNING ALCOHOL- AND DRUG-RELATED TRAFFIC OFFENSES.

Bill Summary

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

Makes numerous changes in statutory provisions relating to criminal actions which involve a person who has consumed an excessive amount of alcohol or drugs.

Section 1 lowers the blood alcohol content required for charging the "per se" driving offense to 0.10; with respect to the "per se" offense and statutory presumptions, allows the required blood alcohol content to be present at the time of the commission of the offense or within two hours thereafter; provides that the type of chemical test given is at the discretion of the law enforcement officer; states that failure of a person to cooperate in the taking of a chemical test is considered a refusal to take the test; provides that the procedures relating to chemical tests are inapplicable in certain criminal cases; and changes the term "intoxicating liquor" to the term "alcohol".

With respect to the revocation of a driver's license based upon an administrative determination, section 2 adds a provision to clearly state the purpose of the administrative revocation section. Section 3 makes changes in the blood alcohol content and the time period it may be present in the same manner noted in section 1; permits law enforcement officers to take possession of the driver's license of a nonresident when he is served with a notice of revocation; allows for an administrative review concerning the revocation prior to the effective date of said revocation; lengthens the period between the notice of revocation and the effective date of the revocation to allow for such review; and provides that a request for a hearing or a petition for judicial review

concerning the revocation does not operate to stay the revocation.

Sections 4 and 5 clarify that chemical tests are to be administered at the direction of a law enforcement officer in vehicular homicide and vehicular assault cases.

Sections 6 to 10 are conforming and technical amendments.

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

SECTION 1. 42-4-1202 (1) (a) and (1.5) (a), the introductory portion to 42-4-1202 (2), and 42-4-1202 (2) (a), (2) (d), (3) (a) (II), (3) (a) (III), (3) (a) (IV), (3) (b), and (3) (d), Colorado Revised Statutes, 1984 Repl. Vol., are amended to read:

42-4-1202. Driving under the influence - driving while impaired - driving with excessive alcoholic content - chemical tests - penalties - useful public service program - alcohol and drug driving safety program. (1) (a) It is a misdemeanor for any person who is under the influence of ~~intoxicating liquor~~ ALCOHOL to drive any vehicle in this state.

(1.5) (a) It is a misdemeanor for any person to drive any vehicle in this state when the amount of alcohol in such person's blood is ~~0.15~~ 0.10 or more grams of alcohol per hundred milliliters of blood or ~~0.15~~ 0.10 or more grams of alcohol per two hundred ten liters of breath at the time of the commission of the alleged offense OR WITHIN TWO HOURS THEREAFTER, as shown by chemical analysis of such person's blood or breath.

(2) In any prosecution for a violation of paragraph (a) or (b) of subsection (1) of this section, the amount of

alcohol in the defendant's blood or breath at the time of the commission of the alleged offense or within ~~a-reasonable-time~~ TWO HOURS thereafter, as shown by chemical analysis of the defendant's blood or breath, shall give rise to the following presumptions:

(a) If there was at such time 0.05 or less grams of alcohol per one hundred milliliters of blood as shown by chemical analysis of such person's blood or if there was at such time 0.05 or less grams of alcohol per two hundred ten liters of breath as shown by chemical analysis of such person's breath, it shall be presumed that the defendant was not under the influence of ~~intoxicating--liquor~~ ALCOHOL and that his ability to operate a vehicle was not impaired by the consumption of alcohol.

(d) The limitations of this subsection (2) shall not be construed as limiting the introduction, reception, or consideration of any other competent evidence bearing upon the question of whether or not the defendant was under the influence of ~~intoxicating-liquor~~ ALCOHOL or whether or not his ability to operate a vehicle was impaired by the consumption of alcohol.

(3) (a) (II) Any person who drives any motor vehicle upon the streets and highways and elsewhere throughout this state may be required to submit to a chemical test OR TESTS of his breath or blood for the purpose of determining the alcoholic content of his blood or breath ~~if-arrested--for--any misdemeanor--offense--arising-out-of-acts-alleged-to-have-been~~

committed--while AT THE REQUEST AND DIRECTION OF A LAW ENFORCEMENT OFFICER HAVING REASONABLE GROUNDS TO BELIEVE THAT the person was driving a motor vehicle in violation of subsection (1) or (1.5) of this section. if-such-person requests-that-said-chemical-test-be-a--blood--test;--then--the test--shall-be-of-his-blood;-but;-if-such-person-requests-that a-specimen-of-his-blood-not-be-drawn;-then-a-specimen--of--his breath--shall-be-obtained-and-tested: THE REQUIREMENTS OF THIS SUBSECTION (3) WHICH RELATE TO THE MANNER IN WHICH CHEMICAL TESTS ARE ADMINISTERED SHALL NOT BE APPLICABLE IF THE LAW ENFORCEMENT OFFICER ALSO HAS REASONABLE GROUNDS TO BELIEVE THAT THE PERSON HAS COMMITTED A VIOLATION OF SECTION 18-3-105, 18-3-106 (1) (b), 18-3-204, OR 18-3-205 (1) (b), C.R.S.

(III) Any person who drives any motor vehicle upon the streets and highways and elsewhere throughout this state may be required to submit to a chemical test OR TESTS of his blood, saliva, and urine for the purpose of determining the drug content within his system if-arrested-for-any-misdemeanor offense--arising--out--of--acts-alleged-to-have-been-committed while AT THE REQUEST AND DIRECTION OF A LAW ENFORCEMENT OFFICER HAVING REASONABLE GROUNDS TO BELIEVE THAT the person was driving a motor vehicle in violation of paragraph (c) or (d) of subsection (1) of this section. THE REQUIREMENTS OF THIS SUBSECTION (3) WHICH RELATE TO THE MANNER IN WHICH CHEMICAL TESTS ARE ADMINISTERED SHALL NOT BE APPLICABLE IF THE LAW ENFORCEMENT OFFICER ALSO HAS REASONABLE GROUNDS TO BELIEVE THAT THE PERSON HAS COMMITTED A VIOLATION OF SECTION 18-3-105,

18-3-106 (1) (b), 18-3-204, OR 18-3-205 (1) (b), C.R.S.

(IV) Any person who is required to submit to ~~or who requests that a specimen of his blood, breath, saliva, or urine be taken or drawn for~~, testing shall cooperate with the person authorized to obtain ~~such specimens~~ A SPECIMEN OF HIS BLOOD, BREATH, SALIVA, OR URINE, including the signing of any release forms required by any person who is authorized to take ~~or withdraw~~ OBTAIN such specimens. ~~If such person refuses to sign any release forms, such refusal shall be considered a refusal to take the tests, provided said forms conform to paragraph (b) of this section.~~ IF SUCH PERSON DOES NOT COOPERATE WITH THE PERSON AUTHORIZED TO OBTAIN SUCH SPECIMENS, SUCH NONCOOPERATION SHALL BE CONSIDERED A REFUSAL TO SUBMIT TO TESTING. No law enforcement officer shall physically restrain any person for the purpose of obtaining a specimen of his blood, breath, saliva, or urine for testing EXCEPT WHEN THE OFFICER HAS REASONABLE GROUNDS TO BELIEVE THAT THE PERSON HAS COMMITTED A VIOLATION OF SECTION 18-3-105, 18-3-106 (1) (b), 18-3-204, OR 18-3-205 (1) (b), C.R.S.

(b) The tests shall be administered at the direction of ~~the arresting~~ A LAW ENFORCEMENT officer having reasonable grounds to believe that the person had been driving a motor vehicle in violation of subsection (1) or (1.5) of this section and in accordance with rules and regulations prescribed by the state board of health, with utmost respect for the constitutional rights, dignity of person, and health of the person being tested. No person except a physician, a

registered nurse, a paramedic, as certified in part 2 of article 3.5 of title 25, C.R.S., an emergency medical technician, as defined in part 1 of article 3.5 of title 25, C.R.S., or a person whose normal duties include withdrawing blood samples under the supervision of a physician or registered nurse shall be entitled to withdraw blood for the purpose of determining the alcoholic or drug content therein. No civil liability shall attach to any person authorized to obtain blood, breath, saliva, or urine specimens or to any hospital in which such specimens are obtained as provided in this subsection (3) as a result of the act of obtaining such specimens from any person submitting thereto if such specimens were obtained according to the rules and regulations prescribed by the state board of health; except that such provision shall not relieve any such person from liability for negligence in the obtaining of any specimen sample.

(d) If a person refuses to take a chemical test as provided in this subsection (3), he shall be subject to license revocation pursuant to the provisions of section 42-2-122.1. Any and all other suspensions, revocations, cancellations, or denials which may be provided by law shall be in addition to and shall commence subsequent to any revocation action provided for in section 42-2-122.1 ~~(1)-(a)~~ ~~(III)~~ (1.5) (a) (II), and any revocation taken under said section shall not preclude other actions which the department is required to take in the administration of the provisions of this title.

SECTION 2. 42-2-122.1 (1), Colorado Revised Statutes, 1984 Repl. Vol., is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

42-2-122.1. Revocation of license or driving privilege based on administrative determination. (1) The purpose of this section is:

(a) To provide safety for all persons using the highways of this state by quickly revoking the drivers' licenses of those persons who have shown themselves to be safety hazards by driving with an excessive amount of alcohol in their bodies and those persons who have refused to submit to a chemical analysis as required by section 42-4-1202 (3);

(b) To guard against the potential for any erroneous deprivation of the driving privilege by providing an opportunity for administrative review prior to the effective date of the revocation and an opportunity for a full hearing as quickly as possible after the revocation becomes effective; and

(c) Following the revocation period, to prevent the relicensing of those persons until the department is satisfied that their alcohol problem is under control and that they no longer constitute a safety hazard to other highway users.

SECTION 3. 42-2-122.1 (3), (4) (a), (4) (b), (5) (a), (5) (c), (6) (c), (7) (a), (7) (e), (8) (c), (8) (e), and (9) (a), Colorado Revised Statutes, 1984 Repl. Vol., are amended, and the said 42-2-122.1 is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

42-2-122.1. Revocation of license or driving privilege based on administrative determination. (1.5) (a) The department shall revoke the license of any person upon its determination that the person:

(I) Drove a vehicle in this state when the amount of alcohol in such person's blood was 0.10 or more grams of alcohol per hundred milliliters of blood or 0.10 or more grams of alcohol per two hundred ten liters of breath at the time of the commission of the alleged offense or within two hours thereafter, as shown by chemical analysis of such person's blood or breath; or

(II) Refused to submit to a chemical analysis of his blood, breath, saliva, or urine as required by section 42-4-1202 (3).

(b) The department shall make a determination of these facts on the basis of the report of a law enforcement officer required in subsection (2) of this section, and this determination shall be final unless an administrative review is requested under subsection (6.5) of this section or a hearing is held under subsection (7) of this section.

(c) The determination of these facts by the department is independent of the determination of the same or similar facts in the adjudication of any criminal charges arising out of the same occurrence. The disposition of those criminal charges shall not affect any revocation under this section.

(d) For purposes of this section, "license" includes driving privilege.

(3) (a) Upon receipt of the report of the law enforcement officer, the department shall make the determination described in subsection ~~(1)~~ (1.5) of this section. If the department determines that the person is subject to license revocation and if notice of revocation has not already been served upon the person by the enforcement officer as required in subsection (4) of this section, the department shall issue a notice of revocation.

(b) The notice of revocation shall be mailed to the person at the last-known address shown on the department's records, IF ANY, and to the address provided by the enforcement officer's report if that address differs from the address of record. The notice is deemed received three days after mailing, unless returned by postal authorities.

(c) The notice of revocation shall clearly specify the reason and statutory grounds for the revocation, the effective date of the revocation, the right of the person to request AN ADMINISTRATIVE REVIEW AND a hearing, the procedure for requesting AN ADMINISTRATIVE REVIEW AND a hearing, and the date by which ~~that~~ A request for ~~a hearing~~ AN ADMINISTRATIVE REVIEW must be made IN ORDER TO RECEIVE A DETERMINATION PRIOR TO THE EFFECTIVE DATE OF THE REVOCATION.

(d) IF THE DEPARTMENT DETERMINES THAT THE PERSON IS NOT SUBJECT TO LICENSE REVOCATION, THE DEPARTMENT SHALL NOTIFY THE PERSON OF ITS DETERMINATION AND SHALL RESCIND ANY ORDER OF REVOCATION SERVED UPON THE PERSON BY THE ENFORCEMENT OFFICER.

(4) (a) Whenever the chemical analysis results are

available to the law enforcement officer while the arrested person is still in custody and where the results, if available, show an alcohol concentration of ~~0.15~~ 0.10 or more grams of alcohol per one hundred milliliters of blood as shown by chemical analysis of such person's blood or ~~0.15~~ 0.10 or more grams of alcohol per two hundred ten liters of breath as shown by chemical analysis of such person's breath or whenever a person refuses to submit to chemical tests as required by section 42-4-1202 (3), the officer, acting on behalf of the department, shall serve the notice of revocation personally on the arrested person.

(b) When the law enforcement officer serves the notice of revocation, the officer shall take possession of any driver's license issued by this state OR ANY OTHER STATE which is held by the person. When the officer takes possession of a valid driver's license issued by this state OR ANY OTHER STATE, the officer, acting on behalf of the department, shall issue a temporary permit which is valid for ~~seven~~ FIFTEEN days after its date of issuance.

(5) (a) The license revocation shall become effective ~~seven~~ FIFTEEN days after the subject person has received the notice of revocation as provided in subsection (4) of this section or is deemed to have received the notice of revocation by mail as provided in subsection (3) of this section. ~~If a written request for a hearing is received by the department within that same seven-day period, the effective date of the revocation shall be stayed until a final order is issued~~

~~following--the--hearing;--except-that-any-delay-in-the-hearing which-is-caused-or-requested-by-the-subject-person-or--counsel representing--that--person--shall--not-result-in-a-stay-of-the revocation-during-the-period-of-delay.~~

(c) (I) Where a license is revoked under subsection ~~(1)(a)--(1)~~ (1.5) (a) (I) of this section and the person is also convicted on criminal charges arising out of the same occurrence for a violation of section 42-4-1202 (1) (a) or (1.5), both the revocation under this section and any suspension, revocation, cancellation, or denial which results from such conviction shall be imposed, but the periods shall run concurrently, and the total period of revocation, suspension, cancellation, or denial shall not exceed the longer of the two periods.

(II) Where a license is revoked under subsection ~~(1)-(a)(II)~~ (1.5) (a) (II) of this section and the person is also convicted on criminal charges arising out of the same occurrence for a violation of section 42-4-1202 (1) or (1.5), any suspension, revocation, cancellation, or denial which results from such conviction and is imposed shall run consecutively with the revocation under this section.

(6) (c) Following a license revocation, the department shall not issue a new license or otherwise restore the driving privilege unless ~~it--is-satisfied;-after-an-investigation-of the-character;-habits;-and-driving-ability-of-the-person;-that it-will-be-safe-to-grant-the--privilege--of--driving--a--motor vehicle-on-the-highways~~ AND UNTIL THE PERSON PRESENTS EVIDENCE

SATISFACTORY TO THE DEPARTMENT THAT THE PERSON'S PROBLEM WITH ALCOHOL USE IS UNDER CONTROL AND THAT IT WILL BE REASONABLY SAFE TO PERMIT THE PERSON TO DRIVE A MOTOR VEHICLE UPON THE HIGHWAYS. NO DRIVING PRIVILEGE MAY BE RESTORED UNTIL ALL APPLICABLE REINSTATEMENT FEES HAVE BEEN PAID.

(6.5) (a) Any person who has received a notice of revocation pursuant to this section may request an administrative review. The request may be accompanied by a sworn statement or statements and any other relevant evidence which the person wants the department to consider in reviewing the determination made pursuant to subsection (1.5) of this section.

(b) When a request for administrative review is made, the department shall review the determination made pursuant to subsection (1.5) of this section. In the review, the department shall give consideration to any relevant sworn statement or other evidence accompanying the request for the review, and to the sworn statement of the law enforcement officer required by subsection (2) of this section. If the department determines, by the preponderance of the evidence, that the person drove a motor vehicle in this state when the amount of alcohol in such person's blood was 0.10 or more grams of alcohol per hundred milliliters of blood or 0.10 or more grams of alcohol per two hundred ten liters of breath at the time of the commission of the alleged offense or within two hours thereafter, as shown by chemical analysis of such person's blood or breath, or that the person refused to submit

to a chemical analysis of his blood, breath, saliva, or urine as required by section 42-4-1202 (3), the department shall sustain the order of revocation. If the evidence does not support such a determination, the department shall rescind the order of revocation. The determination of the department upon administrative review is final unless a hearing is requested pursuant to subsection (7) of this section.

(c) The department shall make a determination upon administrative review prior to the effective date of the revocation order if the request for the review is received by the department within eight days following service of the notice of revocation. Where the request for administrative review is received by the department more than eight days following service of the notice of revocation, the department shall make its determination within seven days following the receipt of the request for review.

(d) A request for administrative review does not stay the license revocation. If the department is unable to make a determination within the time limits specified in paragraph (c) of this subsection (6.5), it shall stay the revocation pending that determination.

(e) The request for administrative review may be made by mail or in person at any office of the department. The department shall provide forms which the person may use to request an administrative review and to submit a sworn statement, but use of the forms is not required.

(f) A person may request and be granted a hearing

pursuant to subsection (7) of this section without first requesting administrative review under this subsection (6.5). Administrative review is not available after a hearing is held.

(7) (a) Any person who has received a notice of revocation may make a written request for a review of the department's determination at a hearing. The request may be made on a form available at each office of the department. If the person's driver's license has not been previously surrendered, it must be surrendered at the time the request for a hearing is made. A REQUEST FOR A HEARING DOES NOT STAY THE LICENSE REVOCATION ORDER.

(e) The hearing shall be scheduled ~~as-soon-as-possible; but-in-no-event-later~~ TO BE HELD AS QUICKLY AS PRACTICABLE WITHIN NOT MORE than sixty days after the filing of the request for a hearing. The department shall provide a written notice of the time and place of the hearing to the party requesting the hearing at least ~~twenty~~ TEN days prior to the scheduled hearing, unless the parties agree to waive this requirement.

(8) (c) The sole issue at the hearing shall be whether by a preponderance of the evidence the person drove a vehicle in this state when the amount of alcohol in such person's blood was ~~0.15~~ 0.10 or more grams of alcohol per hundred milliliters of blood or ~~0.15~~ 0.10 or more grams of alcohol per two hundred ten liters of breath at the time of the commission of the alleged offense OR WITHIN TWO HOURS THEREAFTER, as

shown by chemical analysis of such person's blood or breath, or WHETHER THE PERSON refused to submit to a chemical analysis of his blood, breath, saliva, or urine as required by section 42-4-1202 (3). If the presiding hearing officer finds the affirmative of the issue, the revocation order shall be sustained. If the presiding hearing officer finds the negative of the issue, the revocation order shall be rescinded. UNDER NO CIRCUMSTANCES SHALL THE PRESIDING HEARING OFFICER CONSIDER ANY ISSUE NOT SPECIFIED IN THIS PARAGRAPH (c).

(e) If the person who requested the hearing fails to appear without just cause, the right to a hearing shall be waived, and the DEPARTMENT'S EARLIER determination ~~of the department which is based upon the enforcement officer's report becomes~~ SHALL BE final.

(9) (a) Within thirty days of the issuance of the final determination of the department under this section, a person aggrieved by the determination shall have the right to file a petition for judicial review in the district court in the county of the person's residence. THE FILING OF A PETITION FOR JUDICIAL REVIEW SHALL NOT STAY THE LICENSE REVOCATION ORDER.

SECTION 4. 18-3-106 (4), Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended to read:

18-3-106. Vehicular homicide. (4) CHEMICAL TESTS SHALL BE ADMINISTERED AT THE DIRECTION OF A LAW ENFORCEMENT OFFICER HAVING REASONABLE GROUNDS TO BELIEVE THAT THE PERSON WAS

DRIVING A MOTOR VEHICLE IN VIOLATION OF PARAGRAPH (b) OF SUBSECTION (1) OF THIS SECTION. No person except a physician, a registered nurse, a paramedic, as certified in part 2 of article 3.5 of title 25, C.R.S., an emergency medical technician, as defined in section 25-3.5-103 (8), C.R.S., or a person whose normal duties include withdrawing blood samples under the supervision of a physician or registered nurse shall be entitled to withdraw blood for the purpose of determining the alcoholic or drug content therein. No civil liability shall attach to any person authorized to obtain blood, breath, saliva, or urine specimens or to any hospital in which such specimens are obtained pursuant to this section as a result of the act of obtaining such specimens from any person; except that such provision shall not relieve any such person from liability for negligence in the obtaining of any specimen sample.

SECTION 5. 18-3-205 (4), Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended to read:

18-3-205. Vehicular assault. (4) CHEMICAL TESTS SHALL BE ADMINISTERED AT THE DIRECTION OF A LAW ENFORCEMENT OFFICER HAVING REASONABLE GROUNDS TO BELIEVE THAT THE PERSON WAS DRIVING A MOTOR VEHICLE IN VIOLATION OF PARAGRAPH (b) OF SUBSECTION (1) OF THIS SECTION. No person except a physician, a registered nurse, a paramedic, as certified in part 2 of article 3.5 of title 25, C.R.S., an emergency medical technician, as defined in section 25-3.5-103 (8), C.R.S., or a person whose normal duties include withdrawing blood samples

under the supervision of a physician or registered nurse shall be entitled to withdraw blood for the purpose of determining the alcoholic or drug content therein. No civil liability shall attach to any person authorized to obtain blood, breath, saliva, or urine specimens or to any hospital in which such specimens are obtained pursuant to this section as a result of the act of obtaining such specimens from any person; except that such provision shall not relieve any such person from liability for negligence in the obtaining of any specimen sample.

SECTION 6. 42-2-123 (5) (b) (I), Colorado Revised Statutes, 1984 Repl. Vol., is amended to read:

42-2-123. Authority to suspend or deny license - type of conviction - points. (5) (b) (I) Driving while under the influence of ~~intoxicating liquor~~ ALCOHOL or with an excessive alcoholic content pursuant to section 42-4-1202 (1) (a) or (1.5).....12

SECTION 7. 42-4-108 (1) (d), Colorado Revised Statutes, 1984 Repl. Vol., is amended to read:

42-4-108. Provisions uniform throughout state. (1) (d) In no event shall local authorities have the power to enact by ordinance regulations governing the driving of vehicles by persons under the influence of ~~intoxicating liquor~~ ALCOHOL or OF a controlled substance, as defined in section 12-22-303 (7), C.R.S., or whose ability to operate a vehicle is impaired by the consumption of alcohol OR BY THE USE OF A CONTROLLED SUBSTANCE, AS DEFINED IN SECTION 12-22-303 (7),

C.R.S., the registration of vehicles and the licensing of drivers, the duties and obligations of persons involved in traffic accidents, and vehicle equipment requirements in conflict with the provisions of this article; but said local authorities within their respective jurisdictions shall enforce the state laws pertaining to these subjects, and in every charge of violation the complaint shall specify the section of state law under which the charge is made and the state court having jurisdiction.

SECTION 8. 42-4-705 (3), Colorado Revised Statutes, 1984 Repl. Vol., is amended to read:

42-4-705. Pedestrians on highways. (3) It is unlawful for any person who is under the influence of ~~intoxicating liquors~~ ALCOHOL or OF any controlled substance, as defined in section 12-22-303 (7), C.R.S., or OF ANY stupefying drug to walk or be upon that portion of any highway normally used by moving motor vehicle traffic.

SECTION 9. 43-4-402 (1), Colorado Revised Statutes, 1984 Repl. Vol., is amended to read:

43-4-402. Source of revenues - allocation of moneys. (1) The general assembly shall appropriate moneys annually to the fund in the general appropriation bill. In addition to any other penalty imposed pursuant to section 42-4-1202, C.R.S., every person who is convicted of, pleads guilty to, or receives a deferred sentence pursuant to section 16-7-403, C.R.S., for a violation of any of the offenses specified in section 42-4-1202 (1) OR (1.5), C.R.S., shall be required to

pay fifty dollars which shall be deposited into the fund and ten dollars which shall be deposited into the county treasury of the county in which the conviction occurred.

SECTION 10. Repeal. 42-2-122.1 (7) (b), (7) (c), (7) (d), and (9) (c) and 42-4-1202 (2) (c), Colorado Revised Statutes, 1984 Repl. Vol., are repealed.

SECTION 11. Effective date - applicability. This act shall take effect July 1, 1986, and shall apply to alcohol-related and drug-related traffic offenses occurring on or after said date.

SECTION 12. 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.

BILL 33

A BILL FOR AN ACT

CONCERNING THE COMPILATION OF THE SENTENCES IMPOSED BY DISTRICT COURT JUDGES.

Bill Summary

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

Requires the clerk of the district court in each judicial district to compile and make available weekly the sentences imposed by each judge in the district.

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

SECTION 1. Article 2 of title 13, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

13-2-128. Compilation - sentences received upon conviction of felony. (1) The clerk of the district court in each judicial district shall, once each week, prepare a compilation of the sentences imposed in felony cases by each judge in each district court. Such compilation shall include:

(a) The name of each judge;

(b) The name of each offender and a description of the crime for which he was convicted; and

(c) The sentence imposed by each such judge for each such felony case.

(2) The district clerk of each judicial district shall make available weekly the compilation prepared in accordance with subsection (1) of this section.

SECTION 2. 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.

BILL 34

A BILL FOR AN ACT

CONCERNING MANDATORY SENTENCES FOR VIOLENT CRIMES.

Bill Summary

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

Requires the court to sentence a defendant in accordance with the provisions of the crimes of violence statute when that defendant has been convicted of a crime involving the use of a deadly weapon or the infliction of serious bodily injury to the victim, or of a sexual offense involving the use of force, intimidation, or threat against the victim.

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

SECTION 1. 18-3-202 (2), Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended BY THE ADDITION OF THE FOLLOWING NEW PARAGRAPHS to read:

18-3-202. Assault in the first degree. (2) (c) If a defendant is convicted of assault in the first degree pursuant to paragraph (a), (c), (e), or (f) of subsection (1) of this section, the court shall sentence the defendant in accordance with the provisions of section 16-11-309, C.R.S.

(d) If a defendant is convicted of assault in the first degree pursuant to paragraph (d) of subsection (1) of this section, for an assault involving serious bodily injury which he himself caused while committing or attempting to commit murder, robbery, first degree arson, first or second degree burglary, first degree escape, first degree kidnapping, second degree sexual assault, class 3 felony sexual assault on a child, or attempted first degree sexual assault, or during the immediate flight therefrom, the court shall sentence the defendant in accordance with the provisions of section 16-11-309, C.R.S.

SECTION 2. 18-3-203 (2), Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

18-3-203. Assault in the second degree. (2) (c) If a defendant is convicted of assault in the second degree pursuant to paragraph (b), (d), or (g) of subsection (1) of this section, the court shall sentence the defendant in accordance with the provisions of section 16-11-309, C.R.S.

SECTION 3. 18-3-209 (2), Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended to read:

18-3-209. Assault on the elderly or the handicapped - legislative declaration. (2) If the assault on the elderly or the handicapped is second degree assault and is committed without the circumstances provided in section 18-3-203 (2) (a) being present, it is a class 3 felony. IF THE ASSAULT ON THE ELDERLY OR THE HANDICAPPED IS SECOND DEGREE ASSAULT AS DEFINED

IN SECTION 18-3-203 (1) (b) OR (1) (d), THE COURT SHALL SENTENCE THE DEFENDANT IN ACCORDANCE WITH THE PROVISIONS OF SECTION 16-11-309, C.R.S.

SECTION 4. 18-3-302 (4), Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended to read:

18-3-302. Second degree kidnapping. (4) Second degree kidnapping is a class 3 felony if the kidnapping is accomplished by the use of a deadly weapon but did not include sexual assault or robbery. A DEFENDANT CONVICTED PURSUANT TO THIS SUBSECTION (4) SHALL BE SENTENCED BY THE COURT IN ACCORDANCE WITH THE PROVISIONS OF SECTION 16-11-309, C.R.S.

SECTION 5. 18-3-404, Colorado Revised Statutes, 1978 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to read:

18-3-404. Sexual assault in the third degree. (3) If a defendant is convicted of the class 4 felony of sexual assault in the third degree pursuant to paragraph (e) of subsection (1) and subsection (2) of this section, the court shall sentence the defendant in accordance with the provisions of section 16-11-309, C.R.S.

SECTION 6. 18-3-405, Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

18-3-405. Sexual assault on a child. (3) If a defendant is convicted of the class 3 felony of sexual assault on a child pursuant to paragraph (a) of subsection (2) of this section, the court shall sentence the defendant in accordance

with the provisions of section 16-11-309, C.R.S.

SECTION 7. 18-4-302, Colorado Revised Statutes, 1978 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to read:

18-4-302. Aggravated robbery. (4) If a defendant is convicted of aggravated robbery pursuant to paragraph (b) of subsection (1) of this section, the court shall sentence the defendant in accordance with the provisions of section 16-11-309, C.R.S.

SECTION 8. Effective date - applicability. This act shall take effect July 1, 1986, and shall apply to all offenses committed on or after said date.

SECTION 9. 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.

BILL 35

A BILL FOR AN ACT

CONCERNING THE TRACKING OF OFFENDERS THROUGH THE CRIMINAL JUSTICE SYSTEM.

Bill Summary

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

Requires the reporting of certain information concerning an offender at the different stages of the offender's progress through the criminal justice system. Requires a court to order the fingerprinting of any offender not yet fingerprinted for the charge pending before the court.

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

SECTION 1. Title 16, Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 21

Offender-Based Tracking System

16-21-101. Legislative declaration. The general assembly hereby finds and declares that the creation of an

offender-based tracking system is necessary in order to improve the consistency of data shared by the different elements of the criminal justice system; to allow for the tracking of offenders through the criminal justice system; and to improve the reporting of information concerning persons arrested and cases filed to local law enforcement agencies and the Colorado bureau of investigation.

16-21-102. "Offender" defined. For the purposes of this article, "offender" means any person accused of or convicted of a felony or a misdemeanor.

16-21-103. Information on offenders - required. (1) A law enforcement agency, when requesting the filing of any criminal case, shall submit to the district attorney the offender's full name, including aliases, his date of birth, all dates of arrests, and all arrest and offense numbers, if any, assigned by the law enforcement agency.

(2) A district attorney, when filing any criminal case, shall submit to the court the offender's full name, including aliases, his date of birth, all dates of arrests, all arrest and offense numbers, if any, and the district attorney's case number.

(3) The court or the district attorney, when reporting the disposition of any criminal case to the Colorado bureau of investigation, law enforcement agencies, or the department of corrections, shall provide the offender's full name, including aliases, his date of birth, all dates of arrests, all arrest and offense numbers, if any, the district attorney's case

number, and the district court case number.

(4) The department of corrections or the state board of parole, when reporting an offender's release or transfer to community service to law enforcement agencies, shall provide the offender's full name, including aliases, his date of birth, all dates of arrests, all arrest and offense numbers, if any, the district attorney's case number, the district court case number, and the Colorado bureau of investigation's identification number.

16-21-104. Fingerprinting - ordered by court. (1) The court in any criminal proceeding shall order and cause to be documented the fingerprinting of any offender who has not been arrested or fingerprinted for the charge pending before the court.

(2) Any fingerprints ordered pursuant to subsection (1) of this section shall be forwarded by the court to the Colorado bureau of investigation upon conviction of the offender.

SECTION 2. Effective date. This act shall take effect July 1, 1986.

SECTION 3. 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.

BILL 36

A BILL FOR AN ACT

CONCERNING RISK ASSESSMENT GUIDELINES FOR THE STATE BOARD OF PAROLE.

Bill Summary

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

Establishes risk assessment guidelines to be used by the state board of parole in determining whether or not a person should be released from institutional custody.

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

SECTION 1. 17-22.5-303.5 (2) and (3), Colorado Revised Statutes, 1978 Repl. Vol., as amended, are REPEALED AND REENACTED, WITH AMENDMENTS, to read:

17-22.5-303.5. Parole guidelines. (2) The board shall develop and use objective parole criteria, modeled from the 1984 version of the Iowa risk assessment scale, in evaluating inmates for parole, with the goal of increasing parole rates without increasing the risk to society. The division of criminal justice in the department of public safety shall monitor the board's use of the objective parole criteria,

validate the criteria on Colorado inmates, and report to the general assembly by January 1, 1987, on the impact of the use of the criteria on parole rates, risk to society, and recommended modifications to increase predictive accuracy for Colorado offenders.

(3) As used in this section, "objective parole criteria" means the criteria which statistically have been shown by the 1984 version of the Iowa risk assessment scale to be good predictors of risk to society of release on parole. These criteria include the following weighted factors which shall be combined for a total risk score:

(a) "Current offense score." Offenses shall be counted as current if the offender:

(I) Is currently awaiting adjudication or sentencing for the charge;

(II) Is currently serving a sentence for conviction of the offense;

(III) Was charged for the offense on or after the date of arrest for any offense satisfying subparagraph (I) or (II) of this paragraph (a); or

(IV) Was awaiting adjudication or sentencing for the charge at the time of arrest for any current offense.

(b) (I) "Prior violence score" which attaches the following weight to the offender's history of prior arrests for the following violent felonies:

80 Murder

70 Attempted murder

70	First or second degree sexual assault
70	First degree kidnapping
70	Aggravated robbery
70	First degree burglary
70	First degree arson
60	Manslaughter
60	Attempted first or second degree sexual assault
60	Robbery
60	First or second degree assault
60	Second or third degree arson
50	Criminally negligent homicide
50	Attempted robbery
50	Criminal extortion
40	Attempted first, second, or third degree arson
40	Conspiracy to commit a violent felony up to eight separate counts of violent felonies may be scored.

(II) An arrest is scored under this item if the date of arrest was prior to the date of the most recent arrest counted as current according to this section.

(III) The age of a prior arrest for a violent felony is scored as the number of months from the arrest in question to the current conviction date.

(IV) The severity (S) score for each prior violent felony arrest is computed using the following formula:

(A) Prior violence severity = $\frac{24 \times \text{severity score}}{12 + \text{age score}}$

(B) Add the individual prior violence severity scores for a total prior violence score;

(C) Group the prior violence score as follows:

Prior violence Scoring

General Risk	Violence Risk	Range of P
4	5	91+
2	3	11 - 90
0	0	0 - 10

(c) "Street time score" shall be the number of years from age fourteen to the current conviction date. This score shall be calculated as follows:

(I) Calculate the number of years from age fourteen to the current reference date (to one decimal);

(II) Calculate the total number of years that the offender has been incarcerated in prison, jail, or juvenile detention on prior felony offenses;

(III) Subtract (I) from (II) for raw street time score;

(IV) Group street time scores as follows:

Street time scoring		Street time
General Risk	Violence Risk	Grouping
3	3	0 - 6 years
2	2	6 - 11 years
1	1	11 - 14 years
0	0	14 + years

(d) "Criminal history score" shall weight the offender's

history of prior felony convictions and incarcerations in terms of their severity, disposition, and recency. A felony conviction or incarceration is counted as prior if it occurred prior to the most recent felony conviction for which the offender is sentenced. This score shall be calculated as follows:

(I) Score up to eight counts for each felony conviction or incarceration according to the sentence imposed, the amount of street time following conviction or incarceration to the current commitment date, and the following severity of offense scale:

80	Murder
70	Attempted murder
70	First or second degree sexual assault
70	First degree kidnapping
70	Aggravated robbery
70	First degree burglary
70	First degree arson
60	Manslaughter
60	Attempted first or second degree sexual assault
60	Second degree kidnapping
60	Robbery
60	First or second degree assault
60	Second or third degree arson
50	Criminally negligent homicide
50	Attempted robbery
50	Criminal extortion

50	Escape
40	Conspiracy to commit a violent felony
40	Attempted arson
30	Second or third degree burglary
30	Aggravated motor vehicle theft
30	Forgery
30	Offense relating to a controlled substance
20	Theft
20	Theft by receiving
20	Criminal mischief
20	Offense relating to firearms and weapons
20	Conspiracy to commit a nonviolent felony
10	All other criminal offenses

(II) Felony convictions which resulted in a commitment to a juvenile or adult institution should be multiplied by 1.25.

(III) Felony convictions which did not result in a commitment to a juvenile or adult institution should be multiplied by .75.

(IV) Use the following formula to calculate the offense severity score for each count:

$$\text{Offense severity} = \frac{24 \times \text{severity score} \times \text{disposition multiplier}}{12 + \text{months from offense to current conviction date}}$$

(V) Add the individual offense severity scores for a total offense severity score.

(VI) Calculate the street time weighted offense severity score using the following formula:

Weighted street time severity score =

$$\frac{\text{sum of individual offense severity scores}}{\text{raw street time score (3(c))/10}}$$

(VII) Group the offender's street time weighted offense severity score as follows:

Criminal history scoring

General risk	Violence risk	Range of criminal history scores
6	6	140+
3	5	41 - 139
1	1	16 - 40
0	0	0 - 15

(e) "Current escape score" assigns a disposition weight to arrests for current escapes from prison, jailbreaks, or absconding prior to or following conviction or sentencing. An escape should not be counted if the incident was handled administratively without the recording of an arrest on the offender's record. Arrests for escapes shall be weighted according to disposition as follows:

Current escape score

General risk	Violence risk	Disposition of arrest for escape
3	4	convicted
1	2	arrested/charged only
0	0	net as above

(f) "Substance abuse score" assigns a weight to a history of drug and alcohol abuse for all drugs except cocaine or maruijuana. All information sources, including self-report, not found to be predictive shall be used to score

this item as follows:

Substance abuse score

General risk	Violence risk	Type of substance abuse
5	7	History of PCP use
5	7	History of non-opiate injections
5	7	History of sniffing volatile substance
4	4	History of opiate addiction
3	4	History of heavy hallucinogen use
2	1	History of drug problem
1	1	History of opiate or hallucinogen use
1	1	History of alcohol problem
0	0	No history as above

(g) "Serious offender classification" shall assign the offender the higher of the two possible risk scores. A serious offender classification is assigned if anyone of the following conditions exist:

(I) Current conviction for violent felony;

(II) Current conviction for escape;

(III) Prior conviction for a felony against a person in last five years street time;

(IV) Prior violence score of 35 or more;

(V) Substance abuse score of 7.

(h) The final risk score shall be calculated as follows:

(I) Complete the "X" score by adding the current offense

score, the prior violence score, and the street time score. This will produce a general risk "X" score and a violence risk "X" score.

(II) Complete the "Y" score by adding the criminal history score, the current escape score and the substance abuse score. This will produce a general risk "Y" score and a violence risk "Y" score.

(III) Prepare a general risk assessment matrix using the "GY" scores as the vertical axis and the "GX" score as the horizontal axis as follows:

GENERAL RISK ASSESSMENT

	"X" score				
"Y" score	0-1	2-3	4	5	6+
0	E	E	E	E	P
1	E	E	G	G	P
2	E	G	G	P	P
3-4	E	G	P	P	P
5	E	P	P	P	VP
6	P	P	P	P	VP
7	P	P	P	VP	VP
8+	P	P	VP	VP	VP

KEY: E = Excellent G = Good F = Fair P = Poor VP = Very Poor

The intersection of the "X" score and the "Y" score represents a measure of the offender's overall threat to society.

(IV) Prepare a violence risk assessment matrix using the

"VY" scores as the vertical axis and the "VX" scores as the horizontal axis as follows:

VIOLENCE RISK ASSESSMENT

(Higher rating for serious offender)

	"X" score						
"Y" score	0	1-2	3	4-5	6-7	8	9+
0	E	E	E	E	G	G	F/P
1	E	E	E	G	G/F	F/P	F/P
2-3	E	G	G	G	F/P	F/P	F/P
4-6	E	G/F	F	F/P	F/P	F/P	F/VP
7-8	F	F	F/P	F/P	F/P	F/VP	F/VP
9+	F	F	F/P	F/P	F/VP	F/VP	F/VP

KEY: E = Excellent G = Good F = Fair P = Poor VP = Very Poor

The intersection of the "X" score and the "Y" score represents a measure of the offender's violence risk to society. Risk ratings to the right of the slash are assigned to serious offender classifications.

SECTION 2. Repeal. 17-22.5-303.5 (4), Colorado Revised Statutes, 1978 Repl. Vol., as amended, is repealed.

SECTION 3. Effective date. This act shall take effect July 1, 1986.

SECTION 4. 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.

BILL 37

A BILL FOR AN ACT

CONCERNING THE ESTABLISHMENT OF INTENSIVE SUPERVISION PROBATION PROGRAMS BY THE JUDICIAL DEPARTMENT.

Bill Summary

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

Allows the judicial department to establish intensive supervision probation programs in order to provide an alternative to sentences to the department of corrections.

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

SECTION 1. Part 2 of article 11 of title 16, Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

16-11-213. Intensive supervision probation programs. (1) The general assembly finds and declares that intensive supervision probation programs are an effective and desirable alternative to sentences to imprisonment or community corrections. It is the purpose of this section to encourage the judicial department to establish programs for the

intensive supervision of selected probationers. It is the intent of the general assembly that such programs be formulated so that they protect the safety and welfare of the public in the community where the programs are operating and throughout the state of Colorado.

(2) The judicial department may establish an intensive supervision probation program in any judicial district or combination of judicial districts in order to provide an alternative to the sentencing of selected offenders to the department of corrections.

(3) The judicial department shall require that offenders in the program receive at least the highest level of supervision that is provided to probationers, including daily contact between the offender and the probation officer, either by on-site visits or telephone communication, curfew checks, and employment checks, and shall strive to minimize any risk to the public.

(4) The court may sentence any offender who is otherwise eligible for probation and who would otherwise be sentenced to the department of corrections to an intensive supervision probation program if the court determines that such offender is not a threat to society.

(5) The judicial department shall have the power to establish and enforce standards and criteria for the administration of intensive supervision probation programs.

SECTION 2. 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.

BILL 38

A BILL FOR AN ACT

CONCERNING SERVICES RENDERED AT STATE EXPENSE FOR DEFENDANTS CHARGED WITH TRAFFIC VIOLATIONS.

Bill Summary

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

Provides that supporting services at state expense are not required for a defendant charged with traffic violations if the prosecutor states that he will not seek incarceration as part of the penalty.

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

SECTION 1. 16-5-501, Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended to read:

16-5-501. Prosecuting attorney - incarceration - legal representation and supporting services at state expense. Except as otherwise provided, in any criminal prosecution for class 2 and class 3 misdemeanors, petty offenses, TRAFFIC VIOLATIONS, or municipal code violations, the prosecuting attorney may, at any time during the prosecution, state in

writing whether or not he will seek incarceration as part of the penalty upon conviction of a crime for which the defendant has been charged. If the prosecuting attorney does not seek incarceration as part of such penalty, legal representation and supporting services need not thereafter be provided for the defendant at state expense, and no such defendant shall be incarcerated if found guilty of the charges against him, but the defendant shall be subject to all alternatives available to the court under section 16-11-502 and to alternatives available to each municipality under its municipal code for failure to pay fines and costs.

SECTION 2. Effective date - applicability. This act shall take effect July 1, 1986, and shall apply to acts committed on or after said date.

SECTION 3. 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.

BILL 39

A BILL FOR AN ACT

CONCERNING THE CLARIFICATION OF THE ELEMENTS OF THE CLASS 2 TRAFFIC OFFENSE OF VIOLATING A SPEED LIMIT.

Bill Summary

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

Clarifies that the class 2 traffic offense of violating a speed limit means speeding twenty miles per hour or more over the prima facie speed limit.

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

SECTION 1. 42-4-1001 (7) (i), Colorado Revised Statutes, 1984 Repl. Vol., is amended to read:

42-4-1001. Speed limits. (7) (i) An offense of speeding one to nine miles per hour over the prima facie speed applicable is a class A traffic infraction; an offense of speeding ten to nineteen miles per hour over the prima facie speed applicable is a class A traffic infraction; an offense of speeding twenty miles per hour OR MORE over the prima facie speed applicable is a class 2 traffic offense; and an offense

under subsection (3) of this section is a class A traffic infraction. In every charge of a violation of this subsection (7), the complaint, summons, or notice to appear shall specify the speed at which the defendant is alleged to have driven and also the speed limit applicable at the specified location of the alleged violation.

SECTION 2. Effective date - applicability. This act shall take effect July 1, 1986, and shall apply to acts committed on or after said date.

SECTION 3. 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.

BILL 40

A BILL FOR AN ACT

CONCERNING EXPERT MEDICAL EVIDENCE PRESENTED FOR A DEFENDANT AT A RELEASE HEARING AFTER ENTRY OF A VERDICT OF NOT GUILTY BY REASON OF INSANITY OR IMPAIRED MENTAL CONDITION.

Bill Summary

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

Provides that defendant must present evidence by a medical expert in mental disorders to indicate he is eligible for release at a hearing regarding such defendant's release from commitment after a verdict of not guilty by reason of insanity or impaired mental condition.

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

SECTION 1. 16-8-115 (2), Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended to read:

16-8-115. Release from commitment after verdict of not guilty by reason of insanity or not guilty by reason of impaired mental condition. (2) The court shall order a release examination of the defendant when a current one has

not already been furnished or when either the prosecution or defense moves for an examination of defendant at a different institution or by different experts. The court may order any additional or supplemental examination, investigation, or study which it deems necessary to a proper consideration and determination of the question of eligibility for release. The court shall set the matter for release hearing after it has received all of the reports which it has ordered under this section. When none of said reports indicate the defendant is eligible for release, the defendant's request for release hearing may be denied by the court if the defendant is unable to show by way of an offer of proof any other evidence BY A MEDICAL EXPERT IN MENTAL DISORDERS that would indicate that he is eligible for release. The release hearing shall be to the court or on demand by the defendant to a jury of not to exceed six persons. At the release hearing, if any evidence of insanity is introduced, the defendant has the burden of proving restoration of sanity by a preponderance of the evidence; if any evidence of ineligibility for release by reason of impaired mental condition is introduced, the defendant has the burden of proving, by a preponderance of the evidence, that he is eligible for release by no longer having an impaired mental condition.

SECTION 2. Effective date - applicability. This act shall take effect July 1, 1986, and shall apply to acts committed on or after said date.

SECTION 3. 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.

BILL 41

A BILL FOR AN ACT

CONCERNING OFFENDERS PLACED IN COMMUNITY CORRECTIONAL FACILITIES.

Bill Summary

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

Deletes reference to "violent" or "nonviolent" offenders in the community corrections statutes. Provides that persons whose paroles have been revoked may be placed in community correctional facilities. Allows the corrections board to screen offenders transferred to this state from another state before their placement in a community correctional facility.

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

SECTION 1. 17-27-102 (4), Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended to read:

17-27-102. Definitions. (4) "Offender" means any person accused of or convicted of a felony or a misdemeanor. ~~excluding any person who has committed a crime of violence--as defined--in--section 16-11-309 (2), C.R.S.; and also excluding any person who has committed a class 1 misdemeanor in which--a~~

deadly--weapon-is-used:--For-the-purposes-of-this-article;-the term-"accused"-does-not-include-those-persons-who-are--accused of--crimes--of--violence--as-defined-in-section-16-11-309-(2); C.R.S.;-nor-those--persons--who--are--accused--of--a--class--1 misdemeanor--in--which--a--deadly--weapon--is--used: The term "offender" does not include persons accused of or convicted of class 2 misdemeanor traffic offenses or class A or class B traffic infractions, as specified in article 4 of title 42, C.R.S.

SECTION 2. 17-27-103 (3), Colorado Revised Statutes, 1978 Repl. Vol., as amended, is amended to read:

17-27-103. Community correctional facilities and programs operated by units of local government. (3) The corrections board may establish and enforce standards for the operation of its community correctional facilities and programs and for the conduct of offenders. The corrections board and the department or the judicial district shall establish procedures for screening offenders, INCLUDING OFFENDERS TRANSFERRED TO THIS STATE FROM ANOTHER STATE, who are to be placed in its community correctional facility or program. SUCH PROCEDURES MAY INCLUDE THE USE OF AN OBJECTIVE RISK ASSESSMENT SCALE TO CLASSIFY OFFENDERS IN TERMS OF THEIR RISK TO THE PUBLIC. OFFENDERS SCREENED PURSUANT TO THIS SUBSECTION (3) SHALL BE CLASSIFIED AS HIGH-RISK OR LOW-RISK. The corrections board has the authority to accept, reject, or reject after acceptance the placement of any offender in its community correctional facility or program pursuant to any

contract or agreement with the department or a judicial district. THE CORRECTIONS BOARD MAY ACCEPT, REJECT, OR REJECT AFTER ACCEPTANCE THE PLACEMENT OF ANY OFFENDER, INTRASTATE OR INTERSTATE, IN ANY COMMUNITY CORRECTIONAL FACILITY WITHIN ITS TERRITORIAL JURISDICTION. If an offender is rejected by the corrections board after initial acceptance, the offender shall remain in the custody of the corrections board for a reasonable period of time pending receipt of appropriate orders from the sentencing court or the department for the transfer of such offender. The sentencing court is authorized to make appropriate orders for the transfer of such offender to the department and to resentence such offender and impose any sentence which might originally have been imposed without increasing the length of the original sentence.

SECTION 3. 17-27-104 (3), Colorado Revised Statutes, 1978 Repl. Vol., is amended to read:

17-27-104. Community correctional facilities and programs operated by nongovernmental agencies. (3) The nongovernmental community correctional facility or program has the authority to accept, reject, or reject after acceptance the placement of any offender, INCLUDING OFFENDERS TRANSFERRED TO THIS STATE FROM ANOTHER STATE, in its facility or program pursuant to any contract or agreement with the department or a judicial district. If an offender is rejected by the nongovernmental agency after initial acceptance, the offender shall remain in the custody of the nongovernmental agency for a reasonable period of time pending receipt of appropriate

orders from the judicial district or department for the transfer of such offender.

SECTION 4. 17-27-105 (1), Colorado Revised Statutes, 1978 Repl. Vol., is amended, to read:

17-27-105. Authority of sentencing courts to utilize existing correctional facilities or programs operated by units of local government or nongovernmental agencies. (1) (a) A sentencing judge is authorized to sentence a ~~nonviolent~~ misdemeanor offender to any nonresidential community correctional facility or program operated by a unit of local government or a nongovernmental agency. A sentencing judge is authorized to sentence a ~~nonviolent~~ felony offender to a residential or nonresidential community correctional facility or program operated by a unit of local government or nongovernmental agency. Such facilities and programs may be utilized for such persons who are awaiting sentence, ~~and for~~ persons who have been sentenced, including sentences for probation, AND PERSONS WHOSE PAROLE HAS BEEN REVOKED PURSUANT TO SECTION 17-2-103.

(b) A person charged with a ~~nonviolent~~ misdemeanor offense and granted deferred prosecution or deferred sentencing may be required by the court, as a condition thereof, to participate in a nonresidential community correctional facility or program operated by a unit of local government or a nongovernmental agency.

(c) A person charged with a ~~nonviolent~~ felony offense and granted deferred prosecution or deferred sentencing may be

required by the court, as a condition thereof, to participate in a residential or a nonresidental community correctional facility or program operated by a unit of local government or a nongovernmental agency.

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.

BILL 42

A BILL FOR AN ACT

CONCERNING THE ELEMENTS OF THE OFFENSE OF MANUFACTURING, SELLING, OR DELIVERING DRUG PARAPHERNALIA.

Bill Summary

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

Provides that a person commits a criminal offense if he manufactures, sells, or delivers equipment or materials under circumstances where he should have a reasonable belief that such equipment or materials will be used as drug paraphernalia.

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

SECTION 1. 12-22-505, Colorado Revised Statutes, 1985 Repl. Vol., is amended to read:

12-22-505. Manufacture, sale, or delivery of drug paraphernalia - penalty. Any person who sells or delivers, possesses with intent to sell or deliver, or manufactures with intent to sell or deliver equipment, products, or materials intending OR UNDER CIRCUMSTANCES WHERE HE SHOULD HAVE A REASONABLE BELIEF that such equipment, products, or materials

will be used as drug paraphernalia commits a class 2 misdemeanor and shall be punished as provided in section 18-1-106, C.R.S.

SECTION 2. Effective date - applicability. This act shall take effect July 1, 1986, and shall apply to all acts committed on or after said date.

SECTION 3. 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.