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0336 Joint Review Committee for the Medically Indigent



# COLORADO

## GENERAL ASSEMBLY

Legislative Council  
Research Publication No. 336

**Medically Indigent**

Joint Review Committee for  
the Medically Indigent

**November 1989**

**RECOMMENDATIONS FOR 1990**

**JOINT REVIEW COMMITTEE  
FOR THE MEDICALLY INDIGENT**

**Report to the  
Colorado General Assembly**

**Research Publication No. 336  
November, 1989**

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Rep. Ruth Wright

To Members of the Fifty-Seventh Colorado General Assembly:

Submitted herewith is the final report of the Joint Review Committee for the Medically Indigent. The committee was appointed by the Legislative Council pursuant to Article 15 of Title 26, C.R.S. The purpose of the committee is to give guidance and direction to the University of Colorado Health Sciences Center in the development of the program for the medically indigent and to provide legislative overview of and advice concerning the development of the program.

At its meeting on October 23, 1989, the committee acted to recommend the proposed bills which are detailed herein. These bills were submitted to and approved by the Legislative Council at its meeting on November 9, 1989.

Respectfully submitted,

Representative Carol Taylor-Little  
Chairman, Joint Review Committee  
for the Medically Indigent

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**JOINT REVIEW COMMITTEE  
FOR THE MEDICALLY INDIGENT**

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Sen. Bill Schroeder

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## **ACKNOWLEDGEMENTS**

The Joint Review Committee for the Medically Indigent thanks Don Hoagland, Pat Butler, and Tom Grannemann of the Center for Health Ethics and Policy of the University of Colorado at Denver for the invaluable staff support and research provided to the committee. In addition, the committee thanks the center for assisting with travel expenses for Technical Advisory Committee members living outside of the Denver area. The committee is also grateful for the contributions of Laurie Shroyer and Dr. Stephen Berman of the University of Colorado Health Sciences Center.

The committee recognizes and thanks the National Conference of State Legislatures (NCSL) for its technical assistance and support. Grants from NCSL allowed the committee to learn about the Arizona Health Care Cost Containment System from the program director, Leonard Kirschner; the Oregon Basic Health Services Act from Mark Gibson, Executive Assistant to the President of the Oregon Senate; and the Washington Basic Health Plan from Bruce Ferguson, Associate Executive Director, University of Washington Medical Center.

The Technical Advisory Committee (TAC) was particularly helpful in the work of the Joint Review Committee. The TAC met in evening meetings and before and during lunch of regular committee meetings, lending valuable experience, enhancing committee discussion, and recommending changes to committee proposals. Advisory committee members offered years of experience to the committee as health care providers, accountants/auditors, and representatives of the insurance industry and other public and private fields.

## SUMMARY OF RECOMMENDATIONS

The Joint Review Committee for the Medically Indigent was established in 1983 by the "Reform Act for the Provision of Health Care for the Medically Indigent" (Article 15 of Title 26, C.R.S.). The act states that the committee is to give guidance and direction to the University of Colorado Health Sciences Center in the development of the program for the medically indigent and to provide legislative overview of and advice concerning the development of the program.

As a result of extensive testimony, research, discussion, and the efforts of interested parties, the committee recommends the following six bills for consideration during the 1990 legislative session:

**Health services to the medically indigent.** Bill 1 establishes a system to prioritize health care services and to provide a basic health plan to all Coloradans under the federal poverty level, and authorizes a voluntary employer-sponsored health insurance pool.

**Concerning the medically indigent program.** Bill 2 extends the Medically Indigent Care Program, makes revisions that include increasing services in underserved areas of the state, and makes primary care a higher priority than emergency care.

**Ambulatory health insurance for children.** Bill 3 establishes a program to provide ambulatory health insurance coverage through a managed health care system for uninsured children under age nine.

**Cost reductions in the medically indigent program.** Bill 4 creates a pilot project to reduce costs in the Medically Indigent Program through the use of a capitated system.

**Uncompensated health care.** Bill 5 requires all licensed health professionals in active practice to provide a certain level of uncompensated health care as a condition to maintain licensure.

**Health insurance coverage as an alternative.** Bill 6 allows for the provision of health insurance as an alternative to coverage under the "Workmen's Compensation Act of Colorado."

## **I. Committee Activities**

In an effort to meet its statutory charge, the committee held seven meetings, received testimony from over 50 witnesses, and consulted with recognized experts from Colorado and other states in the medically indigent field.

The Center for Health Ethics and Policy of the University of Colorado at Denver presented an overview of the demographic characteristics of the state's medically indigent and reviewed indigent health care programs in other states.

The Medically Indigent Program administrator at the University of Colorado Health Sciences Center highlighted the program. In addition, Representatives of University Hospital and Denver General Hospital explained the operation of the indigent care program from the perspective of the major providers and made suggestions for possible improvements.

The committee learned about early intervention and prevention programs for the uninsured and underinsured administered by the Department of Health, such as the prenatal care and well child care programs. Various program providers and patient advocates offered their perspectives on the current program, possible program changes, and unique problems associated with providing care to the medically indigent in rural areas.

The Joint Review Committee was also briefed on:

- new approaches to public and private medically indigent programs;
- the medically needy Medicaid option and program options for children;
- the use of health maintenance organizations to serve Medicaid and medically indigent populations;
- insurance issues including private insurance incentives, insurance pools for the medically uninsurable, the Shared Cost Option for Private Employers (SCOPE) program; and
- a variety of other medically indigent issues via public testimony.

A significant amount of time was spent reviewing other state approaches to delivering health care to the medically indigent. The National Conference of State Legislatures sponsored state officials from Arizona, Washington, and Oregon to brief the committee on Arizona's Health Care Cost Containment System (AHCCCS), Oregon's system of prioritizing health care services, and Washington's "Basic Health Plan."

## **II. Issues Reviewed by the Committee**

As an introduction to the committee recommendations, persons concerned with the way health care is delivered throughout the state may be interested in some of the committee's findings relating to key issues of access to care, uncompensated care, and insurance costs and availability. Some of these findings, based on data available, influenced the committee recommendations and are presented below. In addition, data is presented for reference in this report relating to federal poverty levels and estimates of the numbers of persons under various percentages of poverty levels.

### **Access Problems**

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The lack of access to medical care in Colorado is a significant problem, due mostly to financial barriers or to a lack of health care providers in certain rural areas in the state. A 1988 survey by Louis Harris and Associates conducted for the Colorado Trust revealed that:

- Eleven percent of Coloradans reported that they were unable to obtain needed health care. This percentage increases for Hispanics (16 percent), those in fair or poor health (17 percent), and those without health insurance (25 percent). Two percent of the adult population (48,000) reported that they were refused care at some time before the year of the survey.
- Eight percent of Coloradans were unable to keep medical appointments because they lacked transportation. This percentage increased to 18 percent for those with low incomes, 18 percent for blacks, 19 percent for those in fair or poor health, 20 percent for Hispanics, and 25 percent for persons on Medicaid.
- Twelve percent of adult Coloradans reported that they were without health insurance, representing about 280,000 adults.
- An additional 12 percent of adult Coloradans reported that they did not have insurance at some time during the last twelve months; therefore, about 24 percent of the adult population of Colorado, about 570,000 adults, were without health insurance for all or part of the year before the survey.
- People in the lowest income groups are the least likely to have health insurance; 26 percent of persons with household incomes below \$7,500 and 19 percent of families with income between \$7,500 and \$15,000 annually do not have health coverage.

The committee also learned that health care providers are reporting numerous examples of Coloradans unable to get needed care, particularly preventive care such as prenatal care, primary care for acute and chronic conditions, and medications. Many areas of the state have no community clinics and few, if any, physicians to treat uninsured or Medicaid patients.

In addition to financial and geographic barriers, there are many other obstacles to obtaining health care by the medically indigent. The medical system available to the poor often imposes long waiting times to obtain needed care, requires unaffordable up-front co-payments, and imposes a cumbersome eligibility process. When indigent health services are provided, it is through a fragmented delivery system and eligibility standards are not consistent.

### **Uncompensated Care**

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The Colorado Hospital Association reported that Colorado hospitals provided \$147 million in charges for charity care and bad debt in 1988. The Colorado Trust survey reported that the most dissatisfaction with the health care system in Colorado, as well as throughout the U.S., is with its cost. The survey further reported the following figures.

- Some 312,000 Coloradans (13 percent) have medical bills which they are unable to pay. This percentage increases for the uninsured (28 percent), those who have been hospitalized (28 percent), persons in poor health (19 percent), and those with low incomes (20 percent).
- Forty-seven percent of the persons who have been hospitalized in the last 12 months report that they have some unpaid medical bills, and one-quarter of those hospitalized report that they will be unable to pay their medical bills.
- Twenty-five percent of Coloradans have some unpaid medical bills, and 13 percent say they will not be able to pay their medical bills.
- Eight percent of Coloradans reported that they have received free care.
- Ten percent of all adults reported that it has been very difficult for them to pay their health care bills.

## **Insurance Costs**

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Several reasons were cited for why health insurance is not more widely available to different segments of the population. Private health insurance is costly, unaffordable, or unattainable for many individuals and small employers.

- Premium increases to small businesses are now averaging 25 to 50 percent per year. According to a recent National Federation of Independent Business survey, 30 percent of small businesses would have to drop employee coverage if premiums increased 30 percent next year, and 70 percent reported that the price of premiums has kept them out of the market.
- The lack of health insurance is a major obstacle to AFDC recipients becoming self sufficient and moving off welfare. Former welfare recipients working for low wage firms are often not provided insurance coverage. Others cannot obtain the same insurance coverage as available through Medicaid.
- Insurance companies often refuse to insure because of risk, such as an occupation or a pre-existing condition, and sometimes will not cover an entire group due to the health status of one member.
- The recently established SCOPE program reported survey results showing about 90,000 full-time workers in the metropolitan front range area were without health insurance. In response to this need, the SCOPE program offers very low premium insurance with high co-payments for acute care to Denver area employers with fewer than 50 employees.

## **Federal Poverty Levels**

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Parts of existing and proposed legislation make reference to different percentages of federal poverty levels. This term refers to standards that represent an estimated income level a family needs for basic subsistence. The federal poverty level is adjusted for family size and is updated annually. The 1989 federal annual poverty levels are set forth below.

<b>Household Size</b>	<b>75%</b>	<b>100%</b>	<b>150%</b>	<b>185%</b>	<b>200%</b>
1 person	\$4,485	\$ 5,980	\$ 8,970	\$11,063	\$11,960
2 persons	6,015	8,020	12,030	14,837	16,040
3 persons	7,545	10,060	15,090	18,611	20,120
4 persons	9,075	12,100	18,150	22,385	24,200

## Estimated Number of People in Colorado Under Various Poverty Levels

Providing accurate 1989 figures for the number of Coloradans under various federal poverty levels is difficult because current data can only be based on results from the last federal census in 1980. Therefore, the following figures in Table I were estimated by multiplying the various poverty percentages from 1980 by the estimated 1989 Colorado population of 3,301,000. Although the Colorado economic situation has been improving recently, the 1980 census numbers do not reflect Colorado's economic decline in the mid-1980's. A recent University of Wisconsin estimate of Colorado's poverty level for 1985 through 1987 (10.8 percent) showed only a modest increase over the 1980 rate (10.1 percent).

**Table I**

Below Poverty Level of	% of Coloradans Under Various 1980 Poverty Levels	Estimated number of Coloradans Under Various Poverty Levels for 1989	% of U.S. Residents Under Various 1980 Poverty Levels
100 %	10.1 %	333,401	12.5 %
150 %	18.4 %	607,384	21.7 %
200 %	27.7 %	914,377	31.8 %

### III. Committee Recommendations

Based on the issues reviewed by the committee, below are the six legislative recommendations of the Joint Review Committee for the Medically Indigent.

#### **Bill 1 -- Concerning the Provision of Health Services to the Medically Indigent, and, in Connection Therewith, Authorizing a Voluntary Employer-Sponsored Health Insurance Pool**

##### **Colorado Health Services Plan**

Health Services Commission. This proposal affects the eligibility and the medical services to be reimbursed for persons under the Medicaid and medically indigent programs. Bill 1 establishes a health services commission which is directed to develop a list of health services, in priority order, representing the comparative benefits relative to the cost of each service to the entire population to be served. The commission's list is next submitted to an independent actuary who will project the annual cost of the prioritized services. An annual report will be developed containing the service list and actuarial data. The commission is also required to prepare an interim report no later than March 1, 1991.

The commission, appointed by the Governor with consent of the Senate, consists of five physicians, a public health nurse, a social service worker, four nonphysicians with various health care expertise, and four consumers of health care without employment or financial interest in the health care industry.

Program funding. The Joint Review Committee for the Medically Indigent and the Joint Budget Committee make recommendations to the General Assembly concerning the appropriate level of funding for the list of health services. No health service on the list shall be provided unless the appropriation made by the General Assembly is sufficient to cover the actuarially determined cost of that service and all other services on the list with a higher priority.

Adjustments due to insufficient resources. The bill also provides that, if revenues decline, the basic health plan is reduced for the entire eligible population. Health services are reduced by eliminating services in the order of priority starting with the least important and progressing toward the highest priority. Neither the number of eligible persons under the plan nor the payment rate for providers and plans established under the contractual agreement can be reduced to accommodate for declining state revenues.

Managed care contracts. Upon obtaining the necessary Medicaid waivers from the federal government, the Colorado Department of Social Services is required to



develop a system of competitive bidding for managed health care services. The contracted plans are to provide only those services which are funded from the commission's list of services. The initial contract period begins on or after July 1, 1992.

If there is an insufficient number of qualified entities to contract for managed health care services in certain areas of the state, the bill allows the Department of Social Services to continue a fee-for-service payment system to pay for the same services under the health service contracts.

Eligible persons. Persons eligible to receive such prioritized health care services will include those who have been receiving health care services under Medicaid and under the Medically Indigent Program. Two new groups will be eligible under Medicaid: 1) all persons whose family income is below the federal poverty level who are not now eligible for Medicaid; and 2) the medically needy population. The expansion of Medicaid to the new groups, however, is made contingent upon obtaining Medicaid waivers from the federal government and obtaining federal financial participation.

Continuation of existing programs. The Medically Indigent Program and the current Medicaid system are continued until the federal waivers necessary to implement the health care plan in the bill are obtained.

### **Employer-Sponsored Health Insurance**

Insurance pool. The second part of Bill 1 creates an insurance pool governing board to contract with private insurers to provide health insurance policies to small businesses through a state insurance pool. The pool will be open to employers with fewer than 25 employees who have not contributed to employee health insurance within the preceding two years. Other employers may participate in the insurance pool if they elect to join before January 1, 1992.

Employers who participate in the insurance pool are required to pay at least 70 percent of the employees' premiums; the employer may require a minimum employee contribution up to 30 percent. To be eligible, employees must be employed for more than 90 days and for an average of 17.5 hours per week.

Tax credit. As an incentive to participate in the insurance pool, the bill provides a limited tax credit for employer contributions to employees' premiums. The credit will be the lesser of \$25.00 per month per employee or 50 percent of the total monthly premium per employee, or the lesser of \$65.00 or 50 percent of the cost of the monthly premium for each covered employee plus dependents. The tax credits are phased out after a certain number of years.

## **Fiscal Impact**

Colorado Health Services Plan. The cost of providing medical services under the health services plan is assumed to be cost neutral, because the prioritization of services is intended to offset the expansion of eligible persons. The actual outcome will be dependent upon the priority list. Increased funding will be the decision of the General Assembly based upon the services they determine the state needs and can afford. The commission will incur expenses for its meeting costs, staff, and related operating and capital outlay costs.

Employer-sponsored health insurance. Depending on the use of the health insurance part of the bill, general fund revenue will decrease because of the tax credit given to employers for providing insurance coverage to their employees and dependents. The creation of the insurance pool governing board will also result in certain operating costs. The committee hopes that a substantial number of people will shift from the Medically Indigent Program to their own health insurance as a result of this bill.

## **Committee Findings -- Bill 1**

The committee recognizes that the medically indigent problem concerns more than just the low income population. The state's entire health care system must be examined in order to address the medically indigent problem.

Hospital representatives reported that caring for the medically indigent is a statewide problem and questioned whether the state should increase funding to pay adequate indigent care or continue to place the burden on providers who shift the costs of indigent care to paying patients. The amount of charity or bad debt for indigent care in 1988, including Medicaid, was about ten percent of gross revenues for acute care hospitals. Lack of participation in the current indigent care program by rural hospitals is mostly due to insufficient reimbursement levels, according to hospital representatives.

Physicians reported that insufficient public support for the medically indigent places the financial burden of providing such care on the provider. Physicians reiterated that cost shifting to fund indigent care is not fair, because providing such care should be a societal responsibility. The lack of a fully funded medically indigent delivery system creates fragmented services.

Hundreds of thousands of Coloradans have no health insurance and lack the income and resources needed to obtain health care. Without health insurance coverage or the ability to afford health care treatment, these persons often receive health care through more costly emergency room care. Preventive care is frequently unaffordable or unavailable to the indigent or uninsured. The unpaid cost of health services for the indigent is shifted to paying patients, driving up costs of hospitaliza-

tion and health insurance for all other Coloradans. The cost of health care continues to increase. Health care expenditures now consume about 12 percent of the United States GNP.

The health services plan, described in this report is modeled after a program developed in Oregon. The plan is a cooperative effort between the public and medical experts to establish a set of basic health services that all eligible persons should receive. The plan calls for the state to assume responsibility for providing basic health care for those living below the federal poverty level and encourages employers to provide basic health insurance for their employees and dependents. The committee recommends the health services plan in order to:

- increase access to health care;
- develop a program employing preventive and primary care; and
- minimize the medical cost shifts caused by unpaid health services for the indigent, which drives up the cost of medical visits, hospitalization, and health insurance for all Coloradans.

## **Bill 2 -- Concerning the Medically Indigent Health Care Program**

Bill 2 makes changes to the current health care program for the medically indigent. It increases services in geographically underserved regions of the state by adding licensed birth centers to the definition of "general provider." This change allows primary care delivery providers to serve areas of the state where no general providers exist or where an unmet need for primary care exists. The bill changes the priority in benefits covered by designating primary care as the first priority, where appropriate, followed by emergency care.

Separate programs for inpatient care and outpatient care are also established. The mandatory statutory percentages for kinds of care are eliminated, as is the requirement imposed on the University of Colorado Health Sciences Center to establish patient per diem standards for comparable care.

The bill extends the Medically Indigent Program until 1996 and repeals the scheduled termination of the Joint Review Committee's Technical Advisory Committee. The bill states that the General Assembly's intent is that the Medically Indigent Program be replaced when the General Assembly adopts and fully implements a health services plan through the committee's proposed Bill 1.

The committee recommends changes in the current Medically Indigent Program based on the following ideas:

- placing a new emphasis on the provision of cost-effective primary care services, which the committee believes will bring a long-term benefit to the state;
- designing a system that creates incentives to use the least costly care setting; and
- increasing access to such services in underserved areas of the state.

### **Bill 3 -- Concerning the Creation of an Ambulatory Health Care Program for Low-Income Children, and Making an Appropriation Therefor**

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Bill 3 provides ambulatory insurance coverage through a managed health care system for low-income children without health care insurance. The program covers uninsured children less than nine years of age who are eligible under the Medically Indigent Program but are not eligible for medical assistance under Medicaid. Eligible persons are required to pay an enrollment fee of \$25.00 per person that is not to exceed \$150.00 per family in order to participate.

The administrative unit of the University of Colorado Health Sciences Center responsible for the Medically Indigent Program will administer the new program. The administrator is authorized to contract with health care providers through requests for proposals and to seek both private and public funding for operation of the program. The program administrator is to submit an annual report to the General Assembly on the utilization and cost of the program.

A five member Children's Health Policy Board is created to oversee the administration of the program. An appropriation is made for the implementation of the act.

Testimony emphasized the difficulties encountered by low income families in obtaining preventive and immunization services for their children, as well as care for acute illness and chronic disease. The Joint Review Committee found that, with limited resources, it would be beneficial for the state to target children for cost effective primary care services.

## **Bill 4 -- Concerning a Pilot Program for Cost Reductions in the Medically Indigent Program, and Making an Appropriation Therefor**

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In an effort to find new ways of managing care for medically indigent persons, Bill 4 establishes pilot demonstration projects for health care services for this population in selected areas of the state. The bill mandates that the program operate for three years and designates the University of Colorado Health Sciences Center to administer the pilot project through the current Medically Indigent Program.

The program administrator will utilize a system of competitive bidding for prepaid managed health care services. The administrator may negotiate and contract with public and private entities for implementation of the pilot program. Eligibility requirements under the new program will be the same as those for enrollees under the current Medically Indigent Program.

The Technical Advisory Committee on the Medically Indigent will assist the Health Sciences Center in the selection of project sites and in the preparation of the annual report to the General Assembly. An appropriation is made for the implementation of the act.

## **Bill 5 -- Concerning Uncompensated Health Care, and Making an Appropriation Therefor**

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Bill 5 requires regulated health care professionals in active practice to provide a certain number of hours of uncompensated health care annually to medically indigent persons and Medicaid eligible persons as a condition of maintaining their license. Pharmaceutical and medical supply companies are to donate prescription drugs, supplies, and equipment equal to a certain percentage of their gross income attributable to retail sales in Colorado to medically indigent and Medicaid eligible persons. In addition, hospitals and nursing homes are required to provide free days of care to medically indigent and Medicaid eligible persons.

The Department of Social Services is directed to implement a voucher system for medically indigent persons and Medicaid eligible persons to receive care and for proof of participation by regulated health care providers. Regulated health care providers would, however, be able to opt-out of the uncompensated care requirement by paying \$3,000 annually. The bill creates a medically indigent cash fund for such payments.

In addition, a community work requirement is imposed for persons exceeding a certain number of visits to an alcohol and drug treatment facility. The bill provides a tax deduction for regulated health care providers who comply with uncompensated care requirements. An appropriation is made for the implementation of the act.

## **Bill 6 -- Concerning the Provision of Health Insurance for Fifteen or Fewer Employees as an Alternative to Coverage Under the "Workmen's Compensation Act of Colorado"**

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Bill 6 allows employers to offer health insurance in lieu of coverage under the "Workmen's Compensation Act of Colorado" and, if this option is used, to allow employers to retain the same immunity from liability as provided through workmen's compensation coverage. Employers must advise employees of the benefits available under each alternative, and an employee must accept the health insurance and waive his or her rights under workmen's compensation in order for the employer to maintain immunity from liability.

### **Committee Endorsement**

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The Joint Review Committee for the Medically Indigent endorses the proposed legislation by Senator Claire Traylor and Representative Carol Taylor-Little, Concerning the Creation of the Colorado Uninsurable Health Insurance Plan, and Creating a Funding Mechanism and Making an Appropriation Therefor. A critical need in increasing access to health care is assisting uninsurable persons to obtain insurance. The committee recommends that the proposed uninsurable health insurance plan be given serious consideration by the General Assembly during the 1990 legislative session.

### **Committee Principles for Comprehensive Medically Indigent Legislation**

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With the assistance of the Technical Advisory Committee, the Joint Review Committee for the Medically Indigent approved the following principles for the General Assembly to consider when addressing new approaches to health care for the medically indigent.

- Individuals should share in the costs of health care according to their ability to pay.
- Government and the business community should pay a share of the health care costs of people for whom they are each responsible. This includes paying providers reasonable rates and providing access to insurance coverage for the uninsurable, including a premium subsidy.
- All Coloradans should have access to a program of basic health benefits.

- The basic benefits package should be at a socially responsible level and be ranked in priority by its relative contribution to health and the quality of life. Cost effective preventive care is a priority.
- Provide care through a program that incorporates principles of appropriateness, effectiveness, and efficiency.
- The program should include education and incentives toward achieving healthy lifestyles and proper use of the medical care system.
- The program should include incentives for seeking care in the most appropriate and cost effective setting.

## **BACKGROUND REPORT**

This part of the report provides further information as background relating to the legislative history of the Medically Indigent Program and the changes in funding levels and the numbers of providers. The final section outlines options for further change brought to the Joint Review Committee, including outlines of programs for medically indigent in the states of Arizona, Oregon, and Washington.

### **Legislative History -- Colorado Medically Indigent Care Program**

The following is an overview of the key dates and facts relative to the origin and development of the Medically Indigent Program in Colorado.

1974. A legislative Subcommittee on Core City Problems was instrumental in obtaining an appropriation from the General Assembly to provide medically indigent funds to the City and County of Denver for partial support of Denver General Hospital.

The initial authorization for the program was contained in a line item footnote in the Department of Social Service's budget in the 1974 long bill. An appropriation of \$11,950,000, plus \$222,800 for administrative costs, was made to the department for hospitals and health centers owned and operated by municipalities, counties, and hospital districts for the care of indigent patients.

The Department of Social Services was designated as program administrator at the start of the Medically Indigent Program in Colorado. The ability-to-pay fee schedule of the Colorado General Hospital (University Hospital) was used to determine indigence and a minimum charge was required of all patients (\$1.00 for outpatients and \$25.00 for inpatients). Participation was limited to public hospitals, and providers were required to contribute three percent of all operating expenditures to charity prior to becoming eligible for reimbursement from the program.

1975-77. Minor changes occurred in the Medically Indigent Program during this period. No major legislative changes were made in program administration in 1975 and 1977. During 1976, the inpatient minimum charge was reduced from \$25.00 to \$10.00.

1978. Beginning in 1978, physicians at participating facilities were reimbursed for services to indigent patients. In addition, the Community Maternity Program was established as the rural delivery program. The Health Sciences Center subcontracted administration of the Community Maternity Program with the Department of Health.



1981. In 1981, private and not-for-profit hospitals were made eligible for the Medically Indigent Program, but payment for physician services was eliminated. The Department of Social Services was directed to define, by contract, the terms of reimbursement and the services for which reimbursement was to be made. Hospitals were required to utilize the ability-to-pay fee schedule developed for University Hospital by the University of Colorado Board of Regents.

1982. The administration of the program was shifted from the Department of Social Services to the University of Colorado Health Sciences Center in fiscal year 1982-83. The following reasons were given for the program transfer.

- The Health Sciences Center, unlike the Department of Social Services, has statutory authority to provide care for the medically indigent.
- The transfer of this program, along with the transfer of the Community Maternity Program from the Department of Health, provided for the combined administration of medically indigent services in a unit that was an actual provider of medical care.
- It was believed that data gathering capabilities would improve by placing the program in the Health Sciences Center.

1983. In 1983, the General Assembly enacted the "Reform Act for the Provision of Health Care for the Medically Indigent" to provide a statutory base for the Medically Indigent Program, also referred to as the Colorado Indigent Care Program and the Colorado Resident Discount Program (Article 15 of Title 26, C.R.S.).

### **Statutory Provisions**

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The "Reform Act for the Provision of Health Care for the Medically Indigent" sets forth the following major provisions for the statewide program for the medically indigent.

- Section 26-15-104 directs the Health Sciences Center to administer the program and authorizes the center to promulgate necessary rules and regulations.
- Section 26-15-105 requires the center to submit an annual report to the General Assembly concerning specific recommendations and other program features that are deemed appropriate.
- Section 26-15-106 specifies the responsibilities of the Health Sciences Center such as directing the center to execute contracts with providers for payment of costs of services rendered. This section also specifies Denver Health and Hospitals as the primary medically indigent provider for the City and County

of Denver and the Health Sciences Center as the primary provider of medical indigent services for the Denver Standard Metropolitan Statistical Area. The Health Sciences Center is also the provider of "complex care" where such care is not available within the remaining areas of the state.

- Section 26-15-107 establishes the Joint Review Committee for the Medically Indigent "to give guidance and direction to the health sciences center in the development of the program for the medically indigent and to provide legislative overview of and advice concerning the development of the program. . . ."
- Section 26-15-108 creates the Technical Advisory Committee to aid and advise the Joint Review Committee and the Health Sciences Center with respect to the development of the program.

### **Overview of the Colorado Medically Indigent Program**

The legislative intent of the Medically Indigent Program is to "allocate available resources 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." (Section 26-15-102, C.R.S.).

**Eligibility.** An official federal or state definition for "medically indigent" does not exist. Under the Colorado Medically Indigent Care Program, the medically indigent are usually those persons (with little or no personal equity) who are ineligible for Medicaid, yet are still unable to pay for their medical care due to poverty, a lack of health insurance, or inadequate health insurance coverage. Therefore, a patient of the Medically Indigent Program must be medically indigent (based on an ability to pay scale), a Colorado resident or migrant farm worker, and a U.S. citizen or a documented alien. The program serves an estimated 75,000 to 100,000 persons each year.

**Patient responsibilities.** All patients are responsible to pay a portion of their bill determined according to family size, income, assets, liabilities, and extraordinary expenses.

**Services.** The Medically Indigent Program authorizes coverage for most inpatient and outpatient medical services. All providers are also required to provide emergency care (treatment requiring immediate attention) to the indigent. Dental services, nursing home care, chiropractic or podiatric services, sex change surgical procedures, cosmetic surgery, experimental and unapproved Federal Drug Administration treatments are not covered unless deemed medically necessary. In addition, the program

provides inpatient psychiatric and inpatient drug and alcohol service for up to 30 days per patient, per program year.

Due to budget limits, care under the Medically Indigent Program is primarily for acute and emergency conditions. Primary and preventive care are not emphasized. Licensed clinics are authorized to be outpatient providers, but most of the program's budget funds are for hospital care.

Program funding. The program is funded entirely through state funds and, unlike the Medicaid program, is not an entitlement program in which no eligible person can be denied service. Instead, the program is designed to provide payment in the form of reimbursements to providers for the provision of medical services to eligible indigent persons.

Program funding is provided through five fixed line items in the long bill: one each for University Hospital, Denver General Hospital, all non-Denver County providers, "specialty" providers, and maternity providers. The reimbursement rate for providers in each line item category differs depending upon the actual numbers of providers participating, number of patients served, and costs of serving the patients.

In fiscal year 1988-89 providers received the following proportion of their costs for serving indigent patients under the program: University Hospital 59 percent; Denver General Hospital 42 percent; non-Denver County hospitals 34 percent; and speciality providers 36 percent. However, due to increased numbers of providers outside the City and County of Denver, the rate of costs paid has declined from about 50 percent in fiscal year 1985-86 to an estimated 24 percent in fiscal year 1989-90.

### Growth in Appropriations (fiscal years in \$ thousands)

1974-75	\$12,173	1979-80	\$10,369	1984-85	\$33,386
1975-76	10,506	1980-81	12,967	1985-86	40,281
1976-77	10,031	1981-82	15,731	1986-87	40,281
1977-78	9,119	1982-83	19,166	1987-88	40,281
1978-79	10,000	1983-84	35,156	1988-89	41,922
				1989-90	42,322

SOURCE: Annual Report to the Colorado General Assembly, 1987-88 Colorado Indigent Care Programs, University of Colorado Health Sciences Center, February 1989

### Distribution of FY 1989-90 Appropriations (1989 Long Bill)

Community Maternity	\$ 3,349,705
Denver Indigent Care	16,259,496
Out-State Indigent Care	7,058,474
Specialty Care	1,389,078
Health Sciences Center	<u>14,265,520</u>
<b>TOTAL</b>	<b>\$42,322,273</b>

### Patients Served (Fiscal Years 1983-84 and 1987-88)

	1983-84		1987-88
Inpatient	15,426	Inpatient	20,569
Ambulatory	<u>313,134</u>	Ambulatory	<u>400,141</u>
<b>TOTAL</b>	<b>328,560</b>	<b>TOTAL</b>	<b>421,025</b>

SOURCE: Annual Report to the Colorado General Assembly, 1987-88 Colorado Indigent Care Programs, University of Colorado Health Sciences Center, February 1989

Provider participation. Participation in the program has varied from year to year as shown by the following table. Growth in the number of providers has increased every year since fiscal year 1981-82.

<u>Fiscal Year</u>	<u>(Number) and Types of Providers</u>
1974-75	(13): DGH and 12 out-state
1975-76	(8): DGH and 7 out-state
1976-77	(5): DGH and 4 out-state
1977-78	(4): DGH and 3 out-state
1978-79	(4): DGH, 2 out-state, and 1 speciality
1979-80	(3): DGH, 1 out-state, and 1 speciality
1980-81	(3): DGH, 1 out-state, and 1 speciality
1981-82	(3): DGH, 1 out-state, and 1 speciality
1982-83	(15): DGH, 12 out-state, and 2 speciality
1983-84	(29): DGH, UH, 25 out-state, and 2 speciality
1984-85	(31): DGH, UH, 27 out-state, and 2 speciality
1985-86	(36): DGH, UH, 32 out-state, and 2 speciality
1986-87	(41): DGH, UH, 37 out-state, and 2 speciality
1987-88	(49): DGH, UH, 45 out-state, and 2 speciality
1988-89	(57): DGH, UH, 53 out-state, and 2 speciality
1989-90	(63): DGH, UH, 55 out-state, and 6 speciality

SOURCE: Annual Report to the Colorado General Assembly, 1987-88 Colorado Indigent Care Programs, University of Colorado Health Sciences Center, February 1989

## **Medically Indigent Program Options Reviewed by the Committee**

The Joint Review Committee addressed a wide variety of medically indigent program options. Issues were raised through committee testimony, raised by the Technical Advisory Committee, and discussed in the committee's own deliberations. Considerable time was spent reviewing possible Medicaid program expansions and other state approaches to delivering health care to the medically indigent. Officials from the states of Arizona, Oregon, and Washington briefed the committee on their unique health care systems.

### **Possible Colorado Medicaid Expansions**

Colorado Medicaid Program. The Medicaid program provides medical assistance for defined benefits for eligible persons and is administered through the Colorado Department of Social Services within federal guidelines. Coverage includes payment for medical services to aged, blind and disabled persons, single parent families with dependent children, and foster care children.

Many Medicaid providers and patients criticize the program for low payment levels and paperwork burdens that discourage provider participation. In some areas of the state, for example, physicians will not accept new Medicaid patients.

The Colorado Department of Social Services estimates that the Medicaid population for 1989-90 will average about 158,000 persons per month. The Medicaid budget for 1989-90 equals \$536,394,933 (the federal share equals 52.11 percent and state share equals 47.89 percent). The department estimates that about 51 percent of total expenditures for Medicaid will be for long-term health care. Approximately 43 percent of payments will be for the disabled, 35 percent for the aged, and 18 percent for children and adults in families.

Medicaid expansions. The Joint Review Committee reviewed the optional groups under federal law that the state could add to its Medicaid program. Colorado now covers pregnant women and children up to age one with incomes up to 75 percent of the poverty level (100 percent by 1990). This coverage could be expanded to the federal allowable limit of 185 percent of the poverty level.

Recent changes in federal law now allow states to cover children ages one to eight under the federal poverty level. Federal law also requires that the state phase in coverage of children under age seven in AFDC-U (two parent) households with incomes less than the AFDC eligibility standards (now 50 percent of poverty in Colorado). States are also allowed to expand Medicaid to cover children ages seven through eighteen under AFDC standards.

In addition, federal law allows states to expand Medicaid coverage to include the "medically needy." Under this option, states may cover pregnant women and children up to age 18 or other Medicaid categories at an eligibility level up to 133.33 percent of the state's AFDC standard. Persons above medically needy eligibility standards may "spend down" their income by paying for medical care to a level below the eligibility standard and receive assistance in paying for part of their health care costs.

### **Arizona Health Care Cost Containment System**

Until the Arizona Health Care Cost Containment System (AHCCCS) program began in 1982, Arizona was the only state not participating in the federal Medicaid program. Originally, Arizona county governments were responsible for providing indigent health care in the state. When the financial burden of providing such care became an overwhelming responsibility for many counties, Arizona sought an alternative.

Arizona first enacted a Medicaid program in 1974, but did not fund it. In 1977 a state supreme court decision ruled that the enacted Medicaid program needed to be funded. This led to the enactment of the AHCCCS program in 1981, made possible through federal waivers from the U.S. Department of Health and Human Services. The waivers gave the program certain exceptions from traditional Medicaid coverage such as long-term health care and family planning services. In 1988, the program's waiver was extended through 1993 and, in 1989, the program was expanded to include long-term health care.

Unlike typical fee-for-service Medicaid programs, AHCCCS was designed as a prepaid service that provided the indigent the necessary care through capitated managed health care plans. AHCCCS became Arizona's Medicaid program, and Arizona is currently the only state to offer managed care statewide. The goal of AHCCCS administration is to develop an alternative health care delivery and payment system that facilitates cost containment and improves patient access while encouraging quality care and efficient treatment.

## **Oregon Basic Health Services Act**

Because Bill 1 in the Joint Review Committee recommendations is based, in part, on legislation enacted in Oregon, the parallels between Oregon's and Colorado's health care services are explained here. First, Oregon has (approximately) 400,000 citizens who lack health insurance. As a result, costs to care for these medically indigent were shifted to charges borne by third party carriers and paying patients. An estimated 30 percent of the recent insurance premium increases in Oregon were due to this "cost shift." Reportedly, only 160,000 of the 300,000 persons in Oregon living at or below the federal poverty level were being served by the state Medicaid program.

Similar to Colorado, low reimbursement rates and complex billing requirements were reducing the number of providers in the Oregon Medicaid program. In addition, Medicaid caseloads were regularly underestimated, resulting in increased eligibility requirements and cuts in provider reimbursement rates.

In an effort to address the access and Medicaid program problems, Oregon enacted the Basic Health Services Act (Senate Bill 27, 1989 session), which assures access to basic health services to all Oregon citizens at or below the federal poverty level. The basic services provided placed a greater emphasis on preventive care; providing of basic services is expected to cost less per person than previous Medicaid services.

In building its new system, Oregon established a clear social policy as to how limited health care dollars were to be spent. The act provides for a definition of socially acceptable minimum level of care to which everyone should have access by prioritizing health services. The attempt in Oregon has been to design a system of universal health insurance coverage that delivers the determined basic level of care to all citizens.

Health insurance coverage is addressed by two companion proposals. The Oregon Health Insurance Partnership Act (Senate Bill 935, 1989 session) requires businesses to provide adequate health benefits for workers and their dependents. Senate Bill 534 (1989 session) creates the Oregon Medical Insurance Pool Board to supervise a medical insurance risk pool to provide health care services to the uninsured and uninsurable by spreading the cost to as broad a base as possible.

These three bills -- Senate Bills 27, 935, and 534 -- are intended to provide health care access for Oregon's 400,000 uninsured persons. The basic services package is determined by the newly created Health Services Commission consisting of experts in obstetrics/gynecology, pediatrics, general adult medicine, and geriatrics. The commission will review all health services and rank them in the order of the most important to the least important. Costs of each service will be calculated and the complete list will be presented to the legislature and the public. The approved budget will take effect July 1, 1990, if federal funding participation is obtained.



### **Washington Basic Health Plan**

The Washington Basic Health Plan, enacted in 1987, provides a voluntary state-subsidized health insurance package sold directly to individuals. The plan is limited to 30,000 persons with incomes up to 200 percent of the federal poverty level, and the program provides services through a managed care system consisting of five sites. The plan has no annual deductible and provides benefits ranging from doctors visits to hospital care, and from lab tests to child immunizations. The Washington program is intended to supplement current services rather than substitute for a current medically indigent program.

BILL 1

A BILL FOR AN ACT

1 CONCERNING THE PROVISION OF HEALTH SERVICES TO THE MEDICALLY  
2 INDIGENT, AND, IN CONNECTION THEREWITH, AUTHORIZING A  
3 VOLUNTARY EMPLOYER-SPONSORED HEALTH INSURANCE POOL.

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Bill Summary

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

Establishes a health services commission which is directed to develop a list of health services by priority which will be funded under this act. Requires the department of social services to contract for managed care health services which will provide only those services which are funded from such list of services. Provides for reducing in order of priority covered health benefits for the entire population covered by this act if revenues decline. Provides such prioritized health care services to persons who have been receiving health services under medicaid and under the medically indigent program, and to two new groups under medicaid: A new group of "categorically needy" persons comprised of all persons whose family income is at or below the federal poverty level, and the medically needy. Makes the expansion of medicaid to those two groups contingent on the obtaining of medicaid waivers from the federal government and on obtaining federal financial participation. Continues the medically indigent program and the current medicaid system until the necessary federal waivers to implement the health care system detailed in this act are obtained.

Creates an insurance pool governing board which shall contract with private insurers to provide health insurance policies through a state insurance pool to certain small employers who have not recently contributed to employee health

insurance. Requires employers who participate to pay a portion of the employees' premiums. Allows limited tax credits for employer contributions to employees' premiums. Phases out the tax credits after a certain number of years.

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

2 SECTION 1. Title 26, Colorado Revised Statutes, 1989  
3 Repl. Vol., is amended BY THE ADDITION OF A NEW ARTICLE to  
4 read:

5 ARTICLE 4.1

6 Health Services Plan

7 26-4.1-101. Short title. This article shall be known  
8 and may be cited as the "Colorado Health Services Plan".

9 26-4.1-102. Legislative declaration. (1) The general  
10 assembly finds that:

11 (a) Hundreds of thousands of Coloradans have no health  
12 insurance or other coverage and lack the income and resources  
13 needed to obtain health care;

14 (b) The number of persons without access to health  
15 services increases dramatically during periods of high  
16 unemployment;

17 (c) Without health coverage, persons who lack access to  
18 health services may receive treatment, but through more costly  
19 modes of care;

20 (d) The unpaid cost of health services for such persons  
21 is shifted to paying patients, driving up the cost of  
22 hospitalization and health insurance for all Coloradans;

23 (e) The state's medical assistance program is

1 increasingly unable to fund the health care needs of  
2 low-income citizens.

3 (2) In order to provide access to health services for  
4 those in need, to contain rising health services costs through  
5 appropriate incentives to providers, payers, and consumers, to  
6 reduce or eliminate cost shifting, and to promote the  
7 stability of the health services delivery system and the  
8 health and well-being of all citizens, it is the policy of  
9 this state to provide medical assistance as provided in this  
10 article.

11 26-4.1-103. Definitions. As used in this article,  
12 unless the context otherwise requires:

13 (1) "Health services" means at least so much of each of  
14 the following as is approved and funded by the general  
15 assembly:

- 16 (a) Provider services and supplies;
- 17 (b) Outpatient services;
- 18 (c) Inpatient hospital services;
- 19 (d) Health promotion and disease prevention services;
- 20 (e) Long-term care services;
- 21 (f) Preventive care, health education, and early  
22 intervention services.

23 (2) "Medical assistance" means the same as said term is  
24 defined in section 26-4-103 (4). "Medical assistance"  
25 includes "health services" as defined in subsection (1) of  
26 this section.

27 26-4.1-104. Applicability of article - continuation of

1 medically indigent program. (1) This article and the  
2 priority-setting requirements of sections 26-4.1-106 and  
3 26-4.1-109 shall apply to all the health services available to  
4 persons eligible for services under the "Colorado Medical  
5 Assistance Act", article 4 of this title.

6 (2) Until the necessary medicaid waivers are obtained  
7 from the federal government, the medically indigent program  
8 authorized in article 15 of this title shall continue to  
9 provide the health care needs of the medically indigent.

10 26-4.1-105. Health services commission - creation.

11 (1) There is hereby created in the state department of social  
12 services a health services commission, which shall exercise  
13 its powers and perform its duties and functions as if it were  
14 transferred to said department by a type 1 transfer. The  
15 commission shall consist of fifteen members who shall be  
16 appointed by the governor, with the consent of the senate.  
17 Five members shall be physicians licensed to practice medicine  
18 in this state who may have clinical expertise in the general  
19 areas of obstetrics, perinatal care, pediatrics, family  
20 medicine, adult medicine, geriatrics, public health, or  
21 osteopathy. The remaining members shall include a public  
22 health nurse, a social services worker, four persons who are  
23 not physicians but who have relevant expertise in health care  
24 financing, delivery, or ethics, and four consumers of health  
25 care without employment or significant financial interest in  
26 the health care industry. In making the appointments, the  
27 governor shall consult with professional and other interested

1 organizations.

2 (2) Members of the commission shall serve for a term of  
3 four years, at the pleasure of the governor; except that, of  
4 the members first appointed to the commission, three members  
5 shall serve for terms ending July 1, 1992, four members shall  
6 serve for terms ending July 1, 1993, four members shall serve  
7 for terms ending July 1, 1994, and four members shall serve  
8 for terms ending July 1, 1995.

9 (3) Whenever a vacancy exists, the governor shall  
10 appoint a member for the remaining portion of the unexpired  
11 term created by the vacancy, subject to confirmation by the  
12 senate.

13 (4) Members shall receive no compensation for their  
14 services, but shall receive a per diem of seventy-five dollars  
15 a day for attendance at official meetings plus reimbursement  
16 for actual and necessary expenses, including mileage, incurred  
17 in the conduct of official business.

18 (5) The commission may establish such subcommittees of  
19 its members and other medical, economic, or health services  
20 advisers as it determines to be necessary to assist the  
21 commission in the performance of its duties.

22 (6) The commission is authorized to receive  
23 contributions, grants, services, and in-kind donations from  
24 private sources.

25 (7) The commission is authorized to contract with the  
26 center for health ethics and policy of the university of  
27 Colorado at Denver for staff to assist the commission in

1 carrying out its duties and functions.

2 26-4.1-106. Duties of commission - hearings - prepare  
3 list of health services - reports. (1) The health services  
4 commission shall consult with the joint review committee for  
5 the medically indigent, the joint budget committee, and the  
6 house and senate health, environment, welfare, and  
7 institutions committees and conduct public hearings prior to  
8 preparing the health services list described in subsection (3)  
9 of this section. The commission shall solicit testimony and  
10 information from advocates for seniors; handicapped persons;  
11 mental health services consumers; low-income citizens; and  
12 providers of health care, including but not limited to  
13 physicians licensed to practice medicine, dentists, oral  
14 surgeons, chiropractors, naturopaths, hospitals, clinics,  
15 pharmacists, nurses, and allied health professionals. During  
16 the process of preparing the list of health care services  
17 described in subsection (3) of this section, the health  
18 services commission shall consider and use data collected and  
19 developed by available medical outcome research projects.

20 (2) In conjunction with the joint review committee for  
21 the medically indigent, the joint budget committee, and the  
22 house and senate health, environment, welfare, and  
23 institutions committees, the commission shall cause public  
24 involvement to be solicited in a community meeting process to  
25 build a consensus on the values to be used to guide health  
26 resource allocation decisions.

27 (3) The commission shall prepare a list of health

1 services ranked by priority, from the most important to the  
2 least important, representing the comparative benefits  
3 relative to cost of each service to the entire population to  
4 be served.

5 (4) The commission shall submit the list of health  
6 services, as ranked, to an independent actuary retained by the  
7 commission. The actuary shall project the annual cost of  
8 services on the list, and shall report his projections to the  
9 commission.

10 (5) The commission shall annually prepare a single  
11 report containing the list of health services ranked by  
12 priority and incorporating the actuary's projected costs. On  
13 or before November 1, 1991, and every November 1 thereafter,  
14 the commission shall submit such report to the joint review  
15 committee for the medically indigent, the joint budget  
16 committee, the house and senate health, environment, welfare,  
17 and institutions committees, and the governor.

18 (6) The joint review committee for the medically  
19 indigent and the joint budget committee shall make  
20 recommendations to the general assembly about the appropriate  
21 level of funding of the list of health services. After  
22 considering such recommendations and upon determining what  
23 revenues are available to fund all or a portion of the health  
24 services list, the general assembly shall appropriate moneys  
25 to fund all or a portion of the health services list in the  
26 order of priority recommended by the health services  
27 commission, starting with the most important and progressing



1 toward the least important. No health service on the list  
2 shall be provided under this article unless the appropriation  
3 made by the general assembly is sufficient to cover the  
4 actuarially determined cost of that service and all services  
5 on the list with a higher priority.

6 26-4.1-107. Interim report. The health services  
7 commission shall make an interim report to the joint review  
8 committee for the medically indigent, the joint budget  
9 committee, the house and senate health, environment, welfare,  
10 and institutions committees, and the governor no later than  
11 March 1, 1991.

12 26-4.1-108. Managed care health services contracts -  
13 fee-for-service systems. (1) Upon obtaining the necessary  
14 medicaid waivers from the federal government, and pursuant to  
15 rules adopted by the state board, the state department shall  
16 execute managed care health services contracts for the health  
17 services funded pursuant to this article. Such contracts  
18 shall require that all services are provided to the extent and  
19 scope of the health services commission's report for each  
20 service provided under the contract. It is the intent of the  
21 general assembly that the state move toward utilizing full  
22 service managed care health service providers for providing  
23 health services and that the state develop a system of  
24 competitive bidding for capitated contracts for health  
25 services provided under this article. The state department  
26 shall solicit qualified providers or plans to be reimbursed at  
27 competitively determined rates. Such contracts may be made

1 with hospitals and medical organizations, health maintenance  
2 organizations, managed health care plans, and any other  
3 qualified public or private entities. The state department  
4 shall open bidding to any contractors which offer services  
5 within their providers' lawful scopes of practice.

6 (2) The initial contract period shall begin on or after  
7 July 1, 1992.

8 (3) Except for special circumstances recognized in rules  
9 of the state department, all subsequent contracts shall be for  
10 one-year periods starting on July 1, 1993, or on any July 1  
11 thereafter.

12 (4) In the event that there is an insufficient number of  
13 qualified entities to provide for managed care health services  
14 contracts in certain areas of the state, the state department  
15 may continue a fee-for-service payment system for those areas  
16 that pay for the same services provided under the health  
17 services contracts for persons eligible for health services  
18 under this article. In addition, the state department may  
19 make other special arrangements as necessary to increase the  
20 interest of providers in participation in the state's managed  
21 care health services system, including but not limited to the  
22 provision of stop-loss insurance for providers wishing to  
23 limit the amount of risk they wish to underwrite.

24 (5) As provided in subsections (1) and (4) of this  
25 section, the aggregate expenditures by the state department  
26 for health services provided pursuant to this article shall  
27 not exceed the total amounts appropriated for health services

1 under this article.

2 (6) Actions taken by providers, potential providers,  
3 contractors, and bidders in specific accordance with this  
4 article in forming consortiums or in otherwise entering into  
5 contracts to provide health care services shall be performed  
6 pursuant to state supervision, shall be considered to be  
7 lawful trade practices, and shall not be considered to be the  
8 transaction of insurance for purposes of title 10, C.R.S.

9 (7) Health care providers contracting to provide  
10 services under this article shall advise a patient of any  
11 service, treatment, or test that is medically necessary but  
12 not covered under the contract if an ordinarily careful  
13 practitioner in the same or similar community would do so  
14 under the same or similar circumstances.

15 26-4.1-109. Adjustment of health services list due to  
16 insufficient resources. (1) If insufficient resources are  
17 available during a contract period to fund all selected health  
18 services for all eligible persons to be served:

19 (a) The population of eligible persons determined by law  
20 shall not be reduced.

21 (b) The payment rate for providers and plans established  
22 under the contractual agreement shall not be reduced.

23 (2) In the event of insufficient resources as described  
24 in subsection (1) of this section, the health services covered  
25 for a particular fiscal year shall be adjusted by reducing the  
26 health services for the eligible population by eliminating  
27 services in the order of priority recommended by the health

1 services commission, starting with the least important and  
2 progressing toward the most important.

3 (3) If the general assembly is in session, the state  
4 department shall obtain the approval of the general assembly  
5 before instituting the reductions, and if the general assembly  
6 is not in session, the state department shall consult with the  
7 joint budget committee before instituting the reductions. In  
8 addition, providers contracting to provide health services  
9 under this article must be notified at least two weeks prior  
10 to any such legislative consideration of such reductions. Any  
11 reductions made under this section shall take effect no sooner  
12 than sixty days following final legislative consideration of  
13 the reductions.

14 26-4.1-110. Rule-making authority. The state board is  
15 authorized to promulgate reasonable rules and regulations  
16 necessary to implement this article, including rules and  
17 regulations on the requirements for managed care health  
18 services contracts.

19 26-4.1-111. Immunity of health care provider or plan.  
20 Any health care provider or plan contracting to provide  
21 services to the eligible population under this article shall  
22 not be subject to criminal prosecution, civil liability, or  
23 professional disciplinary action for failing to provide a  
24 service which the general assembly has not funded or has  
25 eliminated from its funding pursuant to section 26-4.1-108.

26 26-4.1-112. Authorization of services to persons whose  
27 income exceeds one hundred percent of federal poverty level.

1 Nothing in this article is intended to limit the authority of  
2 the general assembly to authorize services for persons whose  
3 income exceeds one hundred percent of the federal poverty  
4 level for whom federal medical assistance matching funds are  
5 available if state funds are available therefor.

6 SECTION 2. 26-4-103 (2), Colorado Revised Statutes, 1989  
7 Repl. Vol., is amended BY THE ADDITION OF A NEW PARAGRAPH to  
8 read:

9 26-4-103. Definitions. (2) (m) (I) Residents of this  
10 state who are not otherwise categorically needy but whose  
11 family income is at or below the federal poverty level, as  
12 defined pursuant to 42 U.S.C. section 9902(2).

13 (II) This paragraph (m) shall take effect on such date  
14 on or after July 1, 1992, as the necessary medicaid waivers  
15 are obtained from the federal government and federal financial  
16 participation is assured for the program specified in article  
17 4.1 of this title.

18 SECTION 3. 26-4-103, Colorado Revised Statutes, 1989  
19 Repl. Vol., is amended BY THE ADDITION A NEW SUBSECTION to  
20 read:

21 26-4-103. Definitions. (4.2) (a) "Medically needy"  
22 means the following residents of this state:

23 (I) Individuals who would be eligible for the aid to  
24 families with dependent children program authorized in article  
25 2 of this title and in the rules promulgated by the state  
26 department; except that the level of income for such  
27 individuals may be up to one hundred thirty-three percent of

1 the current payment standard promulgated by the state  
2 department for an equivalent-sized family;

3 (II) Individuals under the age of eighteen years who are  
4 living in the home of both natural or adoptive parents and  
5 whose total income, including the income of both parents, does  
6 not exceed one hundred thirty-three percent of the aid to  
7 families with dependent children payment standard promulgated  
8 by the state department even if the principal wage-earning  
9 parent is employed;

10 (III) Every individual sixty-five years of age or older  
11 whose income does not exceed one hundred thirty-three percent  
12 of the aid to families with dependent children payment  
13 standard for one adult as promulgated by the state department;

14 (IV) Every individual who is blind or needy disabled, as  
15 defined pursuant to article 2 of this title, whose income does  
16 not exceed one hundred thirty-three percent of the aid to  
17 families with dependent children payment standard for one  
18 adult as promulgated by the state department;

19 (V) Individuals who would meet the requirements of  
20 subparagraph (I), (II), (III), or (IV) of this paragraph (a)  
21 but whose incomes exceed the levels set out in any of said  
22 subparagraphs, if they have incurred actual medical expenses  
23 in amounts greater than the difference between their actual  
24 incomes and one hundred thirty-three percent of the aid to  
25 families with dependent children payment standards for an  
26 equivalent-sized family.

27 (b) This subsection (4.2) shall take effect on such date

1 on or after July 1, 1992, as the necessary medicaid waivers  
2 are obtained from the federal government and federal financial  
3 participation is assured for the program specified in article  
4 4.1 of this title.

5 SECTION 4. Article 4 of title 26, Colorado Revised  
6 Statutes, 1989 Repl. Vol., is amended BY THE ADDITION OF THE  
7 FOLLOWING NEW SECTIONS to read:

8 26-4-105.1. Basic services for the medically needy.

9 (1) The state department, by rules and regulations, shall  
10 establish a program of medical assistance to provide necessary  
11 medical care for the medically needy. The establishment and  
12 continuation of the program shall be subject to the  
13 availability of federal funds.

14 (2) Services for the medically needy shall be subject to  
15 the provisions of article 4.1 of this title and to rules and  
16 regulations adopted by the state department to conform to  
17 federal law.

18 (3) The state department may limit the availability of  
19 services provided to specific providers.

20 (4) This section shall take effect on such date on or  
21 after July 1, 1992, as the necessary medicaid waivers are  
22 obtained from the federal government and federal financial  
23 participation is assured for the program specified in article  
24 4.1 of this title.

25 SECTION 5. 26-15-113, Colorado Revised Statutes, 1989  
26 Repl. Vol., is amended to read:

27 26-15-113. Continuation of medically indigent program -

1 repeal of article. (1) THE INTENT OF THE GENERAL ASSEMBLY IS  
2 TO REPLACE THE MEDICALLY INDIGENT PROGRAM AUTHORIZED IN THIS  
3 ARTICLE WITH THE HEALTH SERVICES PLAN AUTHORIZED IN ARTICLE  
4 4.1 OF THIS TITLE UPON OBTAINING NECESSARY MEDICAID WAIVERS  
5 FROM THE FEDERAL GOVERNMENT TO IMPLEMENT SUCH PLAN. THE  
6 MEDICALLY INDIGENT PROGRAM AUTHORIZED IN THIS ARTICLE SHALL  
7 CONTINUE TO PROVIDE THE HEALTH CARE NEEDS OF THE MEDICALLY  
8 INDIGENT UNTIL SUCH MEDICAID WAIVERS ARE OBTAINED.

9 (2) This article is repealed, effective July 1, 1990  
10 1996.

11 SECTION 6. Title 10, Colorado Revised Statutes, 1987  
12 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW  
13 ARTICLE to read:

14 ARTICLE 20

15 Employer-sponsored Health Insurance

16 10-20-101. Legislative declaration. The general  
17 assembly declares that the purpose of this article is to  
18 increase access to health insurance by developing a program  
19 employing preventative and primary care and to minimize the  
20 medical care cost shifts caused by the providing of  
21 uncompensated care by hospitals.

22 10-20-102. Definitions. As used in this article, unless  
23 the context otherwise requires:

24 (1) "Board" means the insurance pool governing board  
25 established in section 10-20-103.

26 (2) "Carrier" means an insurance company, nonprofit  
27 hospital and health care service corporation, or health



1 maintenance organization holding a valid certificate of  
2 authority from the insurance commissioner.

3 (3) "Eligible employee" means an employee who is  
4 employed by an employer for an average of at least seventeen  
5 and one-half hours per week and who elects to participate in  
6 one of the group benefit plans provided through board action,  
7 and sole proprietors, business partners, and limited partners.  
8 The term does not include individuals:

9 (a) Engaged as independent contractors;

10 (b) Whose periods of employment are on an intermittent  
11 or irregular basis;

12 (c) Who have been employed by the employer for fewer  
13 than ninety days.

14 (4) "Family member" means an eligible employee's spouse  
15 and any unmarried child or stepchild within age limits and  
16 other conditions imposed by the board with regard to unmarried  
17 children or stepchildren.

18 (5) "Health benefit plan" means a contract for group  
19 medical, surgical, hospital or any other care recognized by  
20 state law and related services and supplies.

21 (6) "Premium" means the monthly or other periodic charge  
22 for a health benefit plan.

23 10-20-103. Insurance pool governing board - creation.

24 (1) There is hereby created in the department of regulatory  
25 agencies an insurance pool governing board, which shall  
26 exercise its powers and perform its duties and functions as if  
27 it were transferred to said department by a type 1 transfer.

1 The insurance pool governing board shall consist of five  
2 voting members appointed by the governor and, as a nonvoting  
3 member, the insurance commissioner or his designee. Of the  
4 members appointed by the governor, two shall be employers who  
5 employ fewer than twenty-five employees, and at least two  
6 shall be knowledgeable about insurance but shall not be  
7 officers or employees of a carrier nor consultants to a  
8 carrier or contractor.

9 (2) The term of office of each member is three years;  
10 except that of the voting members first appointed to the  
11 insurance pool governing board, one shall serve for a term  
12 ending June 30, 1991, one shall serve for a term ending June  
13 30, 1992, one shall serve a term ending June 30, 1993, and two  
14 shall serve for terms ending June 30, 1994. Voting members  
15 serve at the pleasure of the governor. A member is eligible  
16 for reappointment. Whenever a vacancy exists, the governor  
17 shall appoint a member for the remaining portion of the  
18 unexpired term created by the vacancy.

19 (3) Members of the insurance pool governing board shall  
20 not be compensated but shall be reimbursed for necessary  
21 expenses incurred in the performance of their duties.

22 (4) The board shall select one of its voting members as  
23 chairperson and one of its voting or nonvoting members as  
24 vice-chairperson, for such terms and with duties and powers  
25 necessary for the performance of the functions of such offices  
26 as the board determines.

27 (5) A majority of the members of the board constitutes a

1 quorum for the transaction of business.

2 (6) The board shall meet at least once every three  
3 months at a place, day, and hour determined by the board. The  
4 board shall also meet at other times and places specified by  
5 the call of the chairperson or of a majority of the members of  
6 the board.

7 (7) In accordance with applicable provisions of the  
8 "State Administrative Procedure Act", article 4 of title 24,  
9 C.R.S., the board may adopt rules necessary for the  
10 administration of this article.

11 10-20-104. Powers and duties. (1) In carrying out its  
12 duties under this article, the insurance pool governing board  
13 shall:

14 (a) Enter into contracts for administration of this  
15 article, including collection of premiums and paying carriers;

16 (b) Enter into contracts with carriers or health care  
17 providers for health care insurance or services, including  
18 contracts where final payment may be reduced if usage is below  
19 a level fixed in the contract;

20 (c) Retain consultants and employ staff;

21 (d) Set premium rates for employees and employers. In  
22 setting such rates, the board shall set rates at the lowest  
23 reasonable cost. The premium rate for policies offering part  
24 I coverage for employees only which are written during the  
25 first two years of implementation of this article shall not  
26 exceed seventy-five dollars. Thereafter, the board shall  
27 adjust the premium rate, as necessary, to account for

1 inflation.

2 (e) Perform other duties to provide low-cost insurance  
3 plans of types likely to be purchased by eligible employers.

4 (2) Notwithstanding any other benefit plan contracted  
5 for and offered by the board, the board shall contract for a  
6 health benefit plan or plans best designed to meet the needs  
7 and provide for the welfare of eligible employees and  
8 employers.

9 (3) The board may approve more than one carrier for each  
10 type of plan contracted for and offered, but the number of  
11 carriers shall be held to a number consistent with adequate  
12 service to eligible employees and family members.

13 (4) Where appropriate for a contracted and offered  
14 health benefit plan, the board shall provide options under  
15 which an eligible employee may arrange coverage for family  
16 members of the employee.

17 (5) In developing any health benefit plan, the board may  
18 provide an option for additional coverage for eligible  
19 employees and family members at an additional cost or premium.

20 (6) Transfer of enrollment from one plan to another  
21 shall be open to all eligible employees and family members  
22 under rules adopted by the board.

23 (7) If the board requests less service in a health  
24 benefit plan than is otherwise required by state law, a  
25 carrier is not required to offer such service; except that the  
26 board shall not exclude required coverages for low-dose  
27 mammography or for maternity coverage against the expenses of

1 normal pregnancy and childbirth.

2 10-20-105. Authority of board. (1) The board shall  
3 have authority to employ whatever means are reasonably  
4 necessary to carry out the purposes of this act. Such  
5 authority shall include but is not limited to authority to  
6 seek clarification, amendment, modification, suspension, or  
7 termination of any agreement or contract which in the board's  
8 judgment requires such action.

9 (2) The board by order may terminate the participation  
10 of any employer if for a period of three months the employer  
11 fails to perform any action required by this article or by  
12 board rule.

13 10-20-106. Expenses to employee - employer contribution.

14 (1) The monthly contribution of each eligible employee for  
15 health benefit plan coverage shall be the total cost per month  
16 of the benefit coverage afforded under the plan or plans, for  
17 which the employee exercises the option, including the  
18 administrative expenses therefor less the portion thereof  
19 contributed by the employer. An employee may enroll in more  
20 than one option at a time so long as they do not offer  
21 overlapping services.

22 (2) The employer contribution shall be the amount  
23 necessary to pay the cost of the health benefit plan covering  
24 the employer's covered employees, as described in section  
25 10-20-108, and other plans selected by a covered employee for  
26 which the employer does not require the employee to pay,  
27 including the administrative expenses therefor. An employer

1 is not required to enroll an employee who is already enrolled  
2 in a health benefit plan not offered by the insurance pool  
3 governing board.

4 (3) Payroll deductions for such costs as are not payable  
5 by the employer shall be made by the employer upon receipt of  
6 a signed authorization from the employee indicating an  
7 election to participate in the plan covering the employee or  
8 the employee's family members.

9 10-20-107. Eligibility requirements of employer.

10 (1) Except as otherwise provided in subsection (3) of this  
11 section, in order to be eligible to participate in the  
12 programs authorized by this article, an employer shall:

13 (a) Employ no more than twenty-five employees;

14 (b) Have not contributed within the preceding two years  
15 to any insurance premium on behalf of an employee who is to be  
16 covered by the employer's contribution;

17 (c) Make a minimum contribution to be set by the board  
18 toward the premium incurred on behalf of a covered employee.

19 (2) An employer who meets the requirements of subsection  
20 (1) of this section may take a tax credit for the  
21 contributions for health insurance premiums subject to the  
22 requirements of section 39-22-514, C.R.S.

23 (3) An employer who does not meet the requirements of  
24 paragraph (b) of subsection (1) of this section may elect to  
25 provide health insurance on behalf of his employees under this  
26 article and participate in the programs authorized by this  
27 article. If such an election is made prior to January 1,

1 1993, the employer may take a tax credit for the  
2 contributions for health insurance premiums subject to the  
3 requirements of section 39-22-514, C.R.S.

4 10-20-108. Part I coverage. (1) The board shall  
5 contract for health benefit plans which offer part I coverage.  
6 Part I coverage shall focus on episodic acute care, recovery  
7 care for catastrophic illness or accident, primary care, and  
8 preventive care. The coverage applies to covered eligible  
9 employees only.

10 (2) The plan shall have a deductible and a high  
11 stop-loss to insure that no employee is required to pay the  
12 costs of a major accident or illness, beyond the costs of the  
13 deductible, and that part I coverage can be obtained at a low  
14 enough cost to insure accessibility.

15 (3) Subject to subsection (4) of this section, employers  
16 shall pay at least seventy percent of the premium of part I  
17 coverage for each covered eligible employee per month.

18 (4) An employer shall require that all eligible  
19 employees shall participate in and be covered by part I  
20 coverage. An employer may require a minimum employee  
21 contribution not to exceed thirty percent of the premium for  
22 part I coverage described in this section.

23 10-20-109. Part II coverage. (1) The board shall  
24 contract for health benefit plans which offer part II  
25 coverage. Part II coverage shall consist of a variety of  
26 additional benefit packages which an employee may purchase.  
27 All packages shall contain incentives to encourage the

1 employee to utilize services intelligently and in a  
2 cost-effective way and disincentives to discourage  
3 noncost-effective use or services.

4 (2) Additional benefit packages may include coverage for  
5 optical and dental care.

6 (3) Part II packages shall be available to extend  
7 coverage to the employee's family members.

8 (4) In general, part II packages shall not provide  
9 benefits provided in part I coverage.

10 (5) Employers shall pay at least seventy percent of the  
11 premium of part II coverage for each covered eligible employee  
12 per month. An employer may require a minimum contribution not  
13 to exceed thirty percent of the premium for part II coverage  
14 described in this section.

15 (6) The board may establish by rule that certain  
16 packages shall not be available to an employee who is not  
17 covered by a certain other package or packages.

18 SECTION 7. Part 5 of article 22 of title 39, Colorado  
19 Revised Statutes, 1982 Repl. Vol., as amended, is amended BY  
20 THE ADDITION OF A NEW SECTION to read:

21 39-22-514. Credit for providing health insurance for  
22 employees. (1) (a) (I) A taxpayer operating a business in  
23 existence as of January 1, 1991, which has not contributed  
24 within the preceding two years to any health insurance premium  
25 on behalf of its employees and which provides health insurance  
26 on behalf of its eligible employees through the state  
27 insurance pool created in article 20 of title 10, C.R.S.,



1 shall be allowed a credit, in an amount determined under  
2 subsection (2) of this section, against the taxes imposed by  
3 part 1 or part 3 of this article for amounts paid during the  
4 taxable year for contributions for health insurance premiums.

5 (II) The tax credit authorized in this paragraph (a)  
6 shall be applicable to tax years commencing on or after  
7 January 1, 1991, but prior to January 1, 1996.

8 (III) This paragraph (a) is repealed, effective January  
9 1, 1997.

10 (b) (I) A taxpayer operating a business established on  
11 or after January 1, 1991, which provides health insurance on  
12 behalf of its eligible employees through the state insurance  
13 pool created in article 20 of title 10, C.R.S., shall be  
14 allowed a credit, in an amount determined under subsection (2)  
15 of this section, against the taxes imposed by part 1 or part  
16 3 of this article for amounts paid during the taxable year for  
17 contributions for health insurance premiums.

18 (II) The tax credit authorized in this paragraph (b) may  
19 be taken for four income tax years commencing with the income  
20 tax year in which the business is established.

21 (c) (I) A taxpayer operating a business in existence as  
22 of January 1, 1991, which has previously made contributions to  
23 health insurance premiums on behalf of its employees and which  
24 elects prior to January 1, 1992, to provide health insurance  
25 on behalf of its employees through the state insurance pool  
26 created in article 20 of title 10, C.R.S., shall be allowed a  
27 credit, in an amount determined under subsection (2) of this

1 section, against the taxes imposed by part 1 or part 3 of this  
2 article for amounts paid during the taxable year commencing on  
3 or after January 1, 1991, but prior to January 1, 1993, for  
4 contributions for health insurance premiums.

5 (II) This paragraph (c) is repealed, effective January  
6 1, 1994.

7 (2) The amount of the credit allowed by subsection (1)  
8 of this section shall be the lesser of twenty-five dollars per  
9 month per covered eligible employee or fifty percent of the  
10 total amount of the monthly premium per covered eligible  
11 employee or the lesser of sixty-five dollars per month per  
12 covered eligible employee plus dependents or fifty percent of  
13 the cost of the monthly premium for each covered eligible  
14 employee plus dependents. For purposes of this section,  
15 "eligible employee" has the same meaning as defined in section  
16 10-20-102 (3), C.R.S.

17 (3) If the credit allowed by this section is claimed,  
18 the amount of any deduction allowable under this article for  
19 expenses described in this section shall be reduced by the  
20 dollar amount of the credit. The election to claim the credit  
21 shall be made at the time of filing the tax return in  
22 accordance with rules adopted by the executive director.

23 (4) Any amount of expenses paid by a taxpayer taking a  
24 credit under this section shall not be included as income to  
25 the employee for purposes of this title. If such expenses  
26 have been included in arriving at federal taxable income of  
27 the employee, the amount included shall be subtracted in

1 arriving at state taxable income under section 39-22-104.

2 (5) A nonresident shall be allowed the credit computed  
3 in the same manner and subject to the same limitations as the  
4 credit allowed a resident by this section.

5 (6) If a change in the status of a taxpayer from  
6 resident to nonresident to resident occurs, the credit allowed  
7 by this section shall be determined in a manner consistent  
8 with section 39-22-110.

9 (7) Any tax credit otherwise allowable under this  
10 section which is not used by the taxpayer in a particular year  
11 may be carried forward and offset against the taxpayer's tax  
12 liability for the next succeeding tax year.

13 SECTION 8. 39-22-104 (4), Colorado Revised Statutes,  
14 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A  
15 NEW PARAGRAPH to read:

16 39-22-104. Income tax imposed on individuals, estates,  
17 and trusts - single rate. (4) (h) An amount equal to the  
18 expenses paid by an employer on behalf of a covered eligible  
19 employee for the purpose of providing health insurance  
20 pursuant to article 20 of title 10, C.R.S.

21 SECTION 9. 24-1-120 (3), Colorado Revised Statutes, 1988  
22 Repl. Vol., is amended BY THE ADDITION OF A NEW PARAGRAPH to  
23 read:

24 24-1-120. Department of social services - creation.  
25 (3) (e) The health services commission, created by article  
26 4.1 of title 26, C.R.S., shall perform its duties under the  
27 department of social services as if it were transferred to the

1 department by a type 1 transfer.

2 SECTION 10. 24-1-122, Colorado Revised Statutes, 1988  
3 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW  
4 SUBSECTION to read:

5 24-1-122. Department of regulatory agencies - creation.  
6 (6) The insurance pool governing board created in section  
7 10-20-103, C.R.S., shall perform its powers, duties, and  
8 functions under the department of regulatory agencies as if  
9 the same were transferred to the department by a type 1  
10 transfer.

11 SECTION 11. 24-34-104, Colorado Revised Statutes, 1988  
12 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW  
13 SUBSECTION to read:

14 24-34-104. General assembly review of regulatory  
15 agencies and functions for termination, continuation, or  
16 reestablishment. (25.5) The following board in the  
17 department of regulatory agencies shall terminate on July 1,  
18 1996: The insurance pool governing board, created by article  
19 20 of title 10, C.R.S.

20 SECTION 12. Safety clause. The general assembly hereby  
21 finds, determines, and declares that this act is necessary  
22 for the immediate preservation of the public peace, health,  
23 and safety.

BILL 2

A BILL FOR AN ACT

1 CONCERNING THE MEDICALLY INDIGENT HEALTH CARE PROGRAM.

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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 to the health care program for the medically indigent, as follows: Increases services in geographically underserved regions of the state by allowing primary care delivery providers to provide services in areas of the state where no general providers exist or where an unmet need for primary care exists and by adding licensed birth centers to the definition of "general provider"; changes the priority in benefits covered from exclusively emergency care to include required primary care as the first priority, where appropriate, followed by emergency care; creates separate programs for inpatient care and outpatient care. Eliminates the mandatory statutory percentages for different kinds of care. Removes the requirement imposed on the health sciences center to establish patient per diem standards for comparable care.

Extends the program for the medically indigent for a specified number of years. Repeals the scheduled termination of the technical advisory committee on the medically indigent.

States the intent of the general assembly that the medically indigent program shall be replaced in the event the general assembly adopts and authorizes a health services plan through proposed legislation during the 1990 session.

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

3 SECTION 1. 26-15-102 (1) (a) and (2), Colorado Revised

1 Statutes, 1989 Repl. Vol., are amended to read:

2 26-15-102. Legislative declaration. (1) (a) The state  
3 has insufficient resources to pay for all medical services for  
4 persons who are indigent and must therefore allocate available  
5 resources in a manner which will ~~provide--treatment--of--these~~  
6 ~~conditions--constituting--the--most--serious--threats--to--the--health~~  
7 ~~of--such--medically--indigent--persons,~~ as well as increase access  
8 to primary medical care to prevent THE deterioration of the  
9 health conditions among medically indigent people PERSONS AND  
10 WILL PROVIDE THE TREATMENT OF THOSE CONDITIONS CONSTITUTING  
11 THE MOST SERIOUS THREATS TO THE HEALTH OF SUCH MEDICALLY  
12 INDIGENT PERSONS; and

13 (2) The general assembly further determines, finds, and  
14 declares that THE ELIGIBILITY OF medically indigent persons  
15 ~~are--not--entitled~~ to receive medical services rendered under  
16 the conditions specified in subsection (1) of this section as  
17 ~~a--matter--of--right~~ EXISTS ONLY TO THE EXTENT OF AVAILABLE  
18 APPROPRIATIONS, AS WELL AS TO THE EXTENT OF THE INDIVIDUAL  
19 PROVIDER FACILITY'S PHYSICAL, STAFF, AND FINANCIAL  
20 CAPABILITIES. THE GENERAL ASSEMBLY ALSO RECOGNIZES THAT THE  
21 PROGRAM FOR THE MEDICALLY INDIGENT IS A PARTIAL SOLUTION TO  
22 THE HEALTH CARE NEEDS OF COLORADO'S MEDICALLY INDIGENT  
23 CITIZENS. Therefore, medically indigent persons accepting  
24 such medical services FROM SUCH PROGRAM shall be subject to  
25 the limitations and requirements imposed in this article.

26 SECTION 2. 26-15-103, Colorado Revised Statutes, 1989  
27 Repl. Vol., is REPEALED AND REENACTED, WITH AMENDMENTS, to

1 read:

2 26-15-103. Definitions. As used in this article, unless  
3 the context otherwise requires:

4 (1) "Alternative primary care delivery provider" means a  
5 provider designated by the health sciences center for  
6 underserved regions in the state where there are no existing  
7 general provider contracts to perform primary care services or  
8 where an unmet need for primary care exists.

9 (2) "Emergency care" means treatment for conditions of  
10 an acute, severe nature which are life, limb, or disability  
11 threats requiring immediate attention, where any delay in  
12 treatment would, in the judgment of the responsible physician,  
13 threaten life or loss of function of a patient or viable  
14 fetus.

15 (3) "General provider" means any general hospital, birth  
16 center, or community health clinic licensed or certified by  
17 the department of health pursuant to section 25-1-107 (1) (1)  
18 (I) or (1) (1) (II), C.R.S., any health maintenance  
19 organization issued a certificate of authority pursuant to  
20 section 10-17-104, C.R.S., and the health sciences center when  
21 acting pursuant to section 26-15-106 (5) (a) or (5) (b). A  
22 home health agency may also serve as a provider of community  
23 maternity services. For the purposes of the program,  
24 "provider" includes associated physicians. All general  
25 providers participating in the inpatient care program or the  
26 outpatient care program, or both, shall either have  
27 participated in the specialty care program prior to July 1,

1 1990, or be located outside of the city and county of Denver.

2 (4) "Health sciences center" means the academic  
3 institution responsible for the training of the health  
4 professions established by the regents of the university of  
5 Colorado under section 5 of article VIII of the Colorado  
6 constitution.

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

9 (6) "Required primary care services" means medical care  
10 services identified by the health sciences center, excluding  
11 dental services, rendered in a primary care setting, which  
12 promote health or prevent or forestall the future  
13 deterioration of health, or which prevent the use of more  
14 costly care in the future, or both.

15 SECTION 3. 26-15-106 (1) (a) and (1) (b), Colorado  
16 Revised Statutes, 1989 Repl. Vol., are amended to read:

17 26-15-106. Responsibility of the health sciences center  
18 - provider contracts. (1) (a) Execution of such contracts  
19 with providers for payment of costs of medical services  
20 rendered to the medically indigent as the health sciences  
21 center shall determine are necessary for the continuation--of  
22 the--state-funded-programs-for-the-medically-indigent-existing  
23 prior--to--July--1,--1983,---including---any---short-term---or  
24 transitional--contracts--and--contract-extensions-which-may-be  
25 necessary--to--allow--time--for--promulgation--of--rules---and  
26 negotiation-and-execution-of-detailed-contracts PROGRAM;

27 (b) Promulgation of such REASONABLE rules and



1 regulations as are necessary ~~to continuation of said~~ FOR THE  
2 program, including but not limited to matters enumerated in  
3 section 26-15-105 and program scope and content concerning  
4 community maternity programs; and

5 SECTION 4. 26-15-106 (5) (a) (II), Colorado Revised  
6 Statutes, 1989 Repl. Vol., is amended, and the said 26-15-106  
7 (5) is further amended BY THE ADDITION OF THE FOLLOWING NEW  
8 PARAGRAPHS, to read:

9 26-15-106. Responsibility of health sciences center -  
10 provider contracts. (5) (a) The health sciences center,  
11 including associated physicians, shall, up to its physical,  
12 staff, and financial capabilities as provided for under this  
13 program, be the primary provider of medical services to the  
14 medically indigent for the Denver standard PRIMARY  
15 metropolitan statistical area, EXCLUDING THE MEDICALLY  
16 INDIGENT FOR THE CITY AND COUNTY OF DENVER, WHO SHALL RECEIVE  
17 SERVICES FROM DENVER HEALTH AND HOSPITALS, IN ACCORDANCE WITH  
18 SUBPARAGRAPH (I) OF THIS PARAGRAPH (a).

19 (e) It is intended that the inpatient care program use  
20 general providers outside the city and county of Denver and  
21 designated specialty care providers to provide inpatient acute  
22 and tertiary care primarily to residents outside of the city  
23 and county of Denver. At the discretion of the general  
24 provider, associated physicians may provide inpatient  
25 physician services.

26 (f) It is intended that the outpatient care program use  
27 general providers outside the city and county of Denver and

1 designated specialty care providers to provide primary care  
2 medical services in an outpatient setting primarily to  
3 residents outside of the city and county of Denver. At the  
4 discretion of the general provider, associated physicians may  
5 perform services on-site.

6 (g) It is intended that the alternative primary care  
7 delivery provider program provide required primary care  
8 services in geographically underserved regions of the state  
9 where no general provider contracts for primary care exist or  
10 where an unmet need for primary care exists. An emphasis  
11 should be placed on using existing public health service  
12 delivery systems in these areas whenever possible. Associated  
13 office-based physician services normally included within a  
14 public health service delivery system may be included in the  
15 scope of contracts established.

16 SECTION 5. 26-15-106 (6) (b), Colorado Revised Statutes,  
17 1989 Repl. Vol., is REPEALED AND REENACTED, WITH AMENDMENTS,  
18 to read:

19 26-15-106. Responsibility of health sciences center -  
20 provider contracts. (6) (b) Each fiscal year, the contract  
21 amounts for provision of services to the medically indigent  
22 shall be those identified in the general appropriation bill  
23 for the following institutions and other providers: Denver  
24 health and hospitals; university of Colorado health sciences  
25 center; community maternity providers; inpatient care  
26 programs; outpatient care programs; specialty care providers;  
27 and alternative primary care delivery providers.

1 SECTION 6. 26-15-106 (8) (a), Colorado Revised Statutes,  
2 1989 Repl. Vol., is amended to read:

3 26-15-106. Responsibility of the health sciences center  
4 - provider contracts. (8) (a) Contract dollars provided over  
5 the fiscal year will be managed to assure that funds are  
6 available to provide the REQUIRED PRIMARY CARE SERVICES AND  
7 THE emergency CARE services as defined in this article; and

8 SECTION 7. 26-15-106 (9) (b), Colorado Revised Statutes,  
9 1989 Repl. Vol., is REPEALED AND REENACTED, WITH AMENDMENTS,  
10 to read:

11 26-15-106. Responsibility of health sciences center -  
12 provider contracts. (9) (b) Such medical services shall be  
13 prioritized in the following order:

- 14 (I) Required primary care services, where appropriate;  
15 (II) Emergency care for the full year;  
16 (III) Any additional medical care for those conditions  
17 the health sciences center determines to be the most serious  
18 threat to the health of medically indigent persons;  
19 (IV) Any other additional medical care.

20 SECTION 8. 26-15-107, Colorado Revised Statutes, 1989  
21 Repl. Vol., is amended to read:

22 26-15-107. Joint review committee for the medically  
23 indigent. In order to give guidance and direction to the  
24 health sciences center in the development of the program for  
25 the medically indigent and to provide legislative overview of  
26 and advice concerning the development of the program, there is  
27 hereby established the joint review committee for the

1 medically indigent. The membership of the committee shall  
2 consist of six representatives appointed by the speaker of the  
3 house of representatives and four senators appointed by the  
4 president of the senate, who shall be appointed no later than  
5 ten days after the convening of the first regular session of  
6 each general assembly; except that the members for the  
7 fifty-fourth general assembly may be appointed at any time  
8 after June 12, 1983. The appointments shall include  
9 representation from each of the political parties. The  
10 committee shall meet when necessary with providers and the  
11 health sciences center to review progress in the development  
12 of the program. The committee may consult with such experts  
13 as may be necessary. The staffs of the legislative council  
14 and of the state auditor shall assist the committee. THE  
15 JOINT REVIEW COMMITTEE MAY REQUEST FROM TIME TO TIME THAT A  
16 PERFORMANCE AUDIT BE CONDUCTED BY THE STATE AUDITOR OF THE  
17 ADMINISTRATION OF THE MEDICALLY INDIGENT PROGRAM TO BE  
18 CONDUCTED IN CONJUNCTION WITH ANY FINANCIAL POSTAUDIT OF THE  
19 HEALTH SCIENCES CENTER.

20 SECTION 9. 26-15-113, Colorado Revised Statutes, 1989  
21 Repl. Vol., is amended to read:

22 26-15-113. Continuation of medically indigent program -  
23 repeal of article. (1) IN THE EVENT THAT A HEALTH SERVICES  
24 PLAN IS AUTHORIZED TO BE ESTABLISHED AS PROVIDED IN \_\_\_\_\_  
25 BILL NO. 90-\_\_\_\_, OR ANY SIMILAR BILL, AND THE NECESSARY  
26 MEDICAID WAIVERS ARE OBTAINED FROM THE FEDERAL GOVERNMENT TO  
27 IMPLEMENT SUCH PLAN, THEN, IN SUCH EVENT, IT IS THE INTENT OF

1 THE GENERAL ASSEMBLY TO REPLACE THE MEDICALLY INDIGENT PROGRAM  
2 AUTHORIZED IN THIS ARTICLE WITH SUCH HEALTH SERVICES PLAN.  
3 UNTIL SUCH HEALTH SERVICES PLAN IS DEVELOPED AND IMPLEMENTED  
4 AND THE MEDICAID WAIVERS OBTAINED, THE MEDICALLY INDIGENT  
5 PROGRAM AUTHORIZED IN THIS ARTICLE SHALL CONTINUE TO PROVIDE  
6 THE HEALTH CARE NEEDS OF THE MEDICALLY INDIGENT.

7 (2) This article is repealed, effective July 1, 1990  
8 1996.

9 SECTION 10. Repeal. 2-3-1203 (3) (c) (VIII), Colorado  
10 Revised Statutes, 1980 Repl. Vol., as amended, and 26-15-105  
11 (1) (1), 26-15-106 (11) (a), (11) (b), and (12), and 26-15-108  
12 (2), Colorado Revised Statutes, 1989 Repl. Vol., are repealed.

13 SECTION 11. Effective date. This act shall take effect  
14 July 1, 1990.

15 SECTION 12. Safety clause. The general assembly hereby  
16 finds, determines, and declares that this act is necessary  
17 for the immediate preservation of the public peace, health,  
18 and safety.

BILL 3

A BILL FOR AN ACT

1 CONCERNING THE CREATION OF AN AMBULATORY HEALTH CARE PROGRAM  
2 FOR LOW-INCOME CHILDREN, AND MAKING AN APPROPRIATION  
3 THEREFOR.

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Bill Summary

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

Provides ambulatory insurance coverage through a managed health care system for low-income children without health care insurance who are less than nine years of age, who have gross family incomes that are equal to or less than one hundred fifty percent of the federal poverty level, and who are not otherwise insured for covered services.

Requires the administrative unit of the university of Colorado health sciences center that is responsible for medically indigent program administration to administer the program. Authorizes the administrator of the program to contract with health care providers through requests for proposals. Creates the children's health policy board to oversee program administration. Requires persons eligible for the program to pay an enrollment fee. Authorizes the administrator to divide the state into geographic regions for implementation of the program. Requires the administrator to submit an annual report to the general assembly on utilization and cost of the program. Authorizes the administrator to seek both private and public funding for operation of the program. Makes an appropriation for implementation of the act.

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

1 SECTION 1. Title 26, Colorado Revised Statutes, 1989  
2 Repl. Vol., is amended BY THE ADDITION OF A NEW ARTICLE to  
3 read:

4 ARTICLE 16

5 Children's Health Plan

6 26-16-101. Short title. This article shall be known and  
7 may be cited as the "Children's Health Plan Act".

8 26-16-102. Legislative declaration. The general  
9 assembly finds that affordable ambulatory care for low-income  
10 children who are not eligible for medicaid and are not  
11 otherwise insured is of vital concern for the welfare of such  
12 children. This lack of basic health care coverage is  
13 detrimental to the health of low-income children and to the  
14 public welfare, and results in substantial expenditures for  
15 emergency and remedial health care, often at the expense of  
16 health care providers, health care facilities, and all  
17 purchasers of health care, including the state. The use of  
18 managed health care systems has significant potential to  
19 reduce the growth of health care costs incurred by the people  
20 of this state. Therefore, the general assembly finds that a  
21 more cost-effective and efficient means of providing  
22 ambulatory care for low-income children is necessary for the  
23 preservation of the health of its citizenry. The children's  
24 health plan created in this article exists only to the extent  
25 of available appropriations, as well as to the extent of the  
26 individual provider facility's physical, staff, and financial  
27 capabilities.

1           26-16-103. Definitions. As used in this article, unless  
2 the context otherwise requires:

3           (1) "Administrator" or "children's health plan  
4 administrator" means the administrative unit of the university  
5 of Colorado health sciences center responsible for the  
6 administration of the medically indigent program pursuant to  
7 article 15 of this title.

8           (2) "Board" means the children's health policy board  
9 created in section 26-16-106.

10          (3) "Children's health plan" or "plan" means the program  
11 established by this article for the provision of covered  
12 services to eligible persons.

13          (4) "Covered services" means outpatient pediatric  
14 medical services, including, but not limited to, well child  
15 care checkups, immunizations, screening laboratory tests,  
16 visits for acute care for illnesses and injury, ongoing care  
17 for chronic illness, and outpatient surgical services. The  
18 term does not include hospital services, nursing home or  
19 intermediate care facility services, mental health services,  
20 dental services, or chemical dependency services.

21          (5) "Eligible persons" means children who are less than  
22 nine years of age, who are eligible under the medically  
23 indigent program established in article 15 of this title, who  
24 are not eligible for medical assistance under the medical  
25 assistance program pursuant to article 4 of this title, and  
26 who are not otherwise insured for the covered services.

27          (6) "Eligible providers" means health care providers



1 designated by the administrator.

2 (7) "Managed health care system" means any health care  
3 organization, including health care providers, insurers,  
4 health care service contractors, health maintenance  
5 organizations, or any combination thereof, that provides  
6 directly or by contract covered services, as defined by the  
7 administrator and rendered by duly licensed providers, to an  
8 enrolled, defined patient population. Managed care systems  
9 shall provide twenty-four-hour, seven-day-a-week consultation  
10 and shall have primary care providers who are responsible for  
11 approving referrals for other outpatient medical care  
12 services.

13 (8) "Premium" means a periodic payment, based upon  
14 medically indigent program adjusted annual family income,  
15 which an eligible person makes to the plan as consideration  
16 for enrollment in the plan.

17 (9) "Rate" means the per capita amount, negotiated by  
18 the administrator with and paid to a participating managed  
19 health care system, that is based upon the enrollment of  
20 eligible persons in the plan and in that system.

21 (10) "Subsidy" means the difference between the amount  
22 of periodic payment the administrator makes to a managed  
23 health care system on behalf of an eligible person and the  
24 amount determined to be the eligible person's responsibility.

25 26-16-104. Children's health plan established -  
26 administration. The children's health plan is established to  
27 promote access to appropriate primary health care to assure

1 healthy children. The plan shall provide children's health  
2 care services to eligible persons through managed health care  
3 systems as provided in this article. The plan shall be  
4 administered by the administrator, as defined in section  
5 26-16-103 (1).

6 26-16-105. Powers and duties of administrator. (1) The  
7 administrator has the following powers and duties:

8 (a) To design and from time to time revise a schedule of  
9 covered services for eligible persons which may limit coverage  
10 for preexisting conditions;

11 (b) To provide payment for the provision of covered  
12 services by eligible providers;

13 (c) To negotiate, contract, and apply for and expend  
14 moneys from any governmental or private entity and to receive  
15 contributions, grants, services, and in-kind donations from  
16 private sources. The administrator may use such donations to  
17 pay for all or some of the costs of the plan.

18 (d) To contract for marketing efforts to encourage  
19 potentially eligible persons to receive information about the  
20 plan and about other medical care programs administered by the  
21 medically indigent program; and

22 (e) To set up a toll-free telephone number to provide  
23 information about medical programs and to promote access to  
24 the covered services.

25 (2) The board shall divide the state into regions based  
26 upon the number of eligible persons and the number of provider  
27 resources. The administrator may select a region of the state

1 for the initial operation of the plan, taking into account the  
2 levels and rates of unemployment in different areas of the  
3 state, the need to provide basic health care coverage to a  
4 population reasonably representative of the portion of the  
5 state's population that lacks such coverage, and the need for  
6 geographic, demographic, and economic diversity.

7 26-16-106. Children's health policy board - creation -  
8 duties. (1) There is hereby created a children's health  
9 policy board, which shall advise the administrator and carry  
10 out the duties specified in subsection (2) of this section.  
11 The children's health policy board shall be comprised of five  
12 members, appointed by the governor, with senate confirmation.  
13 The five members shall be appointed to have geographic  
14 representation throughout the state and shall be health care  
15 experts who are not providers under the program created in  
16 this article.

17 (2) The board shall have the following powers and  
18 duties:

19 (a) To review and approve policies under the managed  
20 health care systems as provided in this article;

21 (b) To review and select contractors who provide managed  
22 health care services under this article.

23 26-16-107. Application procedures. Applications and  
24 other information shall be made available to provider offices,  
25 local human services agencies, head start programs, school  
26 districts, public and private elementary schools in which  
27 twenty-five percent or more of the students receive free or

1 reduced price lunches, community health offices, and women,  
2 infants and children (WIC) program sites. These sites may  
3 accept applications, collect the enrollment fee, and forward  
4 the forms and fees to the administrator. Otherwise,  
5 applicants may apply directly to the administrator. The  
6 administrator may use individuals' social security numbers as  
7 identifiers for purposes of administering the plan and conduct  
8 data matches to verify income. Applicants shall submit  
9 evidence of family income, earned and unearned, that will be  
10 used to verify income eligibility. Notwithstanding any other  
11 law to the contrary, benefits under this article are secondary  
12 to a plan of insurance or benefit program under which an  
13 eligible person may have coverage. The administrator shall  
14 identify eligible persons who may have coverage or benefits  
15 under other plans of insurance or who become eligible for  
16 medical assistance.

17       26-16-108. Enrollment fee - children's health plan cash  
18 fund - state contribution. An annual enrollment fee of  
19 twenty-five dollars, not to exceed one hundred fifty dollars  
20 per family, is required from the family of each eligible  
21 person for children's health services. Enrollment fees shall  
22 be deposited in the children's health plan cash fund, which  
23 fund is hereby established. All moneys in the fund are  
24 continuously appropriated to the administrator for the  
25 children's health plan. The administrator shall make an  
26 annual redetermination of continued eligibility and identify  
27 people who may become eligible for medical assistance. The

1 state contribution shall be thirteen dollars per month or one  
2 hundred fifty-six dollars per year for enrollment of each  
3 eligible person. The administrator shall negotiate rates for  
4 covered services, subject to the approval of the board.

5 26-16-109. Participation by managed health care systems.

6 (1) Managed health care systems participating in the plan  
7 shall do so by contract with the administrator and shall  
8 provide, directly or by contract with other health care  
9 providers, covered services to each eligible person. A  
10 participating managed health care system may offer, without  
11 additional cost, health care benefits or services not included  
12 in the schedule of covered services under the plan. A  
13 participating managed health care system shall not give  
14 preference in enrollment to eligible persons who accept such  
15 additional health care benefits or services. Managed health  
16 care systems participating in the plan shall not discriminate  
17 against any potential or current eligible person based upon  
18 health status, sex, race, ethnicity, or religion. The  
19 administrator may receive and act upon complaints from  
20 enrollees regarding failure to provide covered services or  
21 efforts to obtain payment, other than authorized copayments,  
22 for covered services directly from eligible persons, but  
23 nothing in this article empowers the administrator to impose  
24 any sanctions under any professional or facility licensing  
25 statute.

26 (2) The plan shall allow, at least annually, an  
27 opportunity for eligible persons to transfer their enrollments

1 among participating managed health care systems serving their  
2 respective areas. The administrator shall establish a period  
3 of at least twenty days in a given year when this opportunity  
4 is afforded eligible persons, and in those areas served by  
5 more than one participating managed health care system the  
6 administrator shall endeavor to establish a uniform period for  
7 such opportunity. The plan shall allow eligible persons to  
8 transfer their enrollment to another participating managed  
9 health care system at any time upon a showing of good cause  
10 for the transfer.

11 (3) Prior to negotiating with any managed health care  
12 system, the administrator shall determine, on an actuarially  
13 sound basis, the reasonable cost of providing the schedule of  
14 basic health care services, expressed in terms of upper and  
15 lower limits, and recognizing variations in the costs of  
16 providing the services through the various systems and in  
17 different areas of the state. In negotiating with managed  
18 health care systems for participation in the plan, the  
19 administrator shall adopt a uniform procedure that includes at  
20 least all of the following:

21 (a) The administrator shall issue a request for  
22 proposals, including standards regarding the quality of  
23 services to be provided, financial integrity of the responding  
24 systems, and responsiveness to the unmet health care needs of  
25 the local communities or populations that may be served.

26 (b) The administrator shall then review responsive  
27 proposals and may negotiate with respondents to the extent

1 necessary to refine any proposals.

2 (c) Subject to the approval of the board, the  
3 administrator may then select one or more systems to provide  
4 the covered services within a local area.

5 (d) The administrator may adopt a policy that gives  
6 preference to respondents, such as nonprofit community health  
7 clinics, that have a history of providing quality health care  
8 services to low-income persons.

9 26-16-110. Waiver of medicaid. The administrator shall  
10 have authority to request the state department of social  
11 services to apply for a medicaid waiver from the federal  
12 department of health and human services in order to secure  
13 federal funding for the plan.

14 26-16-111. Report concerning the plan. The  
15 administrator shall prepare an annual report and submit such  
16 report to the general assembly by March 1 of each year  
17 concerning the children's health plan established under this  
18 article. The report shall include, but shall not be limited  
19 to, utilization and costs, and shall be prepared after  
20 consultation with health care providers, state personnel, and  
21 other agencies, organizations, or individuals as the  
22 administrator deems appropriate in order to obtain  
23 comprehensive and objective information about the plan.

24 26-16-112. Rule-making authority. The administrator is  
25 authorized to promulgate reasonable rules and regulations to  
26 effectuate the duties and responsibilities set forth in  
27 section 26-16-105.

1           26-16-113. Reservation of legislative power. The  
2 general assembly reserves the right to amend or repeal all or  
3 any part of this article at any time and there shall be no  
4 vested private right of any kind against such amendment or  
5 repeal. All the rights, privileges, or immunities conferred  
6 by this article or any acts done pursuant thereto shall exist  
7 subject to the power of the general assembly to amend or  
8 repeal this article at any time.

9           26-16-114. Repeal of article. This article is repealed,  
10 effective July 1, 1993.

11           SECTION 2. Appropriation - appropriations in long bill  
12 to be adjusted. (1) In addition to any other appropriation,  
13 there is hereby appropriated, out of any moneys in the general  
14 fund not otherwise appropriated, to the  
15 \_\_\_\_\_, for the fiscal year  
16 beginning July 1, 1990, the sum of \_\_\_\_\_ dollars  
17 (\$ \_\_\_\_\_), or so much thereof as may be necessary, for the  
18 implementation of this act.

19           SECTION 3. Effective date. This act shall take effect  
20 July 1, 1990.

21           SECTION 4. Safety clause. The general assembly hereby  
22 finds, determines, and declares that this act is necessary  
23 for the immediate preservation of the public peace, health,  
24 and safety.



BILL 4

A BILL FOR AN ACT

1 CONCERNING A PILOT PROGRAM FOR COST REDUCTIONS IN THE  
2 MEDICALLY INDIGENT PROGRAM, AND MAKING AN APPROPRIATION  
3 THEREFOR.

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Bill Summary

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

Establishes a pilot program of demonstration projects for health care services for the medically indigent in selected geographical areas of the state. Mandates that the program shall operate for a period of three years. Designates the health sciences center to administer the program through the current medically indigent program. Authorizes the health sciences center to utilize a system of enrollment, including but not limited to a capitated managed health care system. States that eligibility requirements for enrollees under the pilot program shall be the same as the eligibility requirements under the medically indigent program. Authorizes the health sciences center to negotiate and contract with public and private entities for implementation of the pilot program. Requires the health sciences center to make an annual report to the general assembly on the progress of the program. Requires the technical advisory committee on the medically indigent to assist the health sciences center in selection of a project site and in preparation of the annual report to the general assembly. Authorizes the health sciences center to promulgate rules and regulations for implementation of the project. Makes an appropriation for implementation of the act.

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

2 SECTION 1. Article 15 of title 26, Colorado Revised  
3 Statutes, 1989 Repl. Vol., is amended BY THE ADDITION OF A  
4 NEW SECTION to read:

5 26-15-106.5. Creation of pilot program on the medically  
6 indigent. (1) The health sciences center shall develop and  
7 implement a pilot program to explore options to:

8 (a) Reduce the state's current annual cost of serving  
9 the medically indigent population;

10 (b) Reduce the number of medically indigent citizens;  
11 and

12 (c) Reduce total expenditures in the medically indigent  
13 project over the long term.

14 (2) For the purpose of establishing the pilot program,  
15 the health sciences center shall establish demonstration  
16 projects in selected geographical areas of the state to  
17 provide necessary basic health care services to indigent  
18 persons who lack coverage at a cost to these persons that does  
19 not create barriers to the utilization of such services.

20 (3) The health sciences center may utilize a capitated  
21 system to design and implement a structure of copayments  
22 through a managed health care system for enrollees. The  
23 structure shall discourage inappropriate enrollee utilization  
24 of health care services but shall not be so costly to  
25 enrollees as to constitute a barrier to appropriate  
26 utilization of necessary health care services. The eligibility  
27 requirements for enrollees under this pilot program shall be

1 the same for persons eligible for medical services under this  
2 article.

3 (4) To initiate the pilot program, the health sciences  
4 center is authorized to negotiate and contract with and to  
5 apply for and expend moneys from any governmental entity and  
6 to receive contributions, grants, services, and in-kind  
7 donations from private sources. The administrator may use  
8 such donations to pay for all or some of the costs of the  
9 plan.

10 (5) The pilot program shall be conducted over a  
11 three-year period. The health sciences center shall establish  
12 and implement demonstration projects during the first year of  
13 the project. The health sciences center shall monitor the  
14 program in terms of utilization and cost during the second  
15 year of the program. In the third and final year of the  
16 program, the health sciences center shall perform and prepare  
17 a complete evaluation of the program over the three-year  
18 period.

19 (6) The state auditor shall conduct a performance audit  
20 of the program at the end of eighteen months and again after  
21 thirty months.

22 (7) The health sciences center shall prepare an annual  
23 report of its findings and recommendations and submit such  
24 report to the general assembly by March 1, 1991, and annually  
25 thereafter.

26 (8) The health sciences center is authorized to  
27 promulgate reasonable rules and regulations necessary for

1 implementation and administration of the pilot program  
2 established under this section. Such rules and regulations  
3 shall be promulgated in accordance with article 4 of title 24,  
4 C.R.S.

5 (9) The appropriation for the pilot program shall be at  
6 least five hundred thousand dollars annually with no reduction  
7 in the current level of appropriations for medically indigent  
8 program, and no more than ten percent of the appropriations  
9 for the pilot program shall be appropriated for administration  
10 of the pilot program. Notwithstanding section 24-75-102,  
11 C.R.S., any appropriated moneys unexpended and unencumbered at  
12 the end of any fiscal year shall not revert to the fund from  
13 which appropriated but shall remain available for expenditure  
14 in subsequent fiscal years.

15 (10) This section is repealed, effective July 1, 1993.

16 SECTION 2. 26-15-108, Colorado Revised Statutes, 1989  
17 Repl. Vol., is amended to read:

18 26-15-108. Technical advisory committee - sunset review.

19 (1) There is hereby created a technical advisory committee on  
20 the medically indigent to aid and advise the joint review  
21 committee for the medically indigent and the health sciences  
22 center with respect to the development of the program AND TO  
23 AID AND ADVISE IN THE IMPLEMENTATION OF THE PILOT PROGRAM FOR  
24 THE MEDICALLY INDIGENT ESTABLISHED PURSUANT TO SECTION  
25 26-15-106.5. The state auditor shall appoint a committee, not  
26 to exceed nine members, comprised of providers, accountants or  
27 auditors, representatives of the health insurance industry,

1 public members, and any other persons offering technical  
2 expertise. The technical advisory committee shall assist in  
3 the development of the program requirements and review and  
4 comment on the report provided for in section 26-15-105. THE  
5 TECHNICAL ADVISORY COMMITTEE SHALL ASSIST THE HEALTH SCIENCES  
6 CENTER IN TERMS OF PRIORITIZATION AND SELECTION OF A SITE FOR  
7 IMPLEMENTATION OF THE PILOT PROGRAM ESTABLISHED PURSUANT TO  
8 SECTION 26-15-106.5 AND SHALL ASSIST IN PREPARATION OF THE  
9 ANNUAL REPORT TO THE GENERAL ASSEMBLY ON THE PROGRAM.

10 (2) (a) This section is repealed, effective July 1, ~~1990~~  
11 1993.

12 (b) Prior to said repeal, the technical advisory  
13 committee on the medically indigent shall be reviewed as  
14 provided for in section 2-3-1203, C.R.S.

15 SECTION 3. 2-3-1203 (3) (f), Colorado Revised Statutes,  
16 1980 Repl. Vol., as amended, is amended BY THE ADDITION OF A  
17 NEW SUBPARAGRAPH to read:

18 2-3-1203. Sunset review of advisory committees.

19 (3) (f) (XVI) The technical advisory committee on the  
20 medically indigent, appointed pursuant to section 26-15-108,  
21 C.R.S.

22 SECTION 4. Repeal. 2-3-1203 (3) (c) (VIII), Colorado  
23 Revised Statutes, 1980 Repl. Vol., as amended, is repealed.

24 SECTION 5. Appropriation. In addition to any other  
25 appropriation, there is hereby appropriated, out of any moneys  
26 in the general fund not otherwise appropriated, to the  
27 department of higher education for allocation to the health

1 sciences center, for the fiscal year beginning July 1, 1990,  
2 the sum of \_\_\_\_\_ dollars (\$ \_\_\_\_\_), or so much  
3 thereof as may be necessary, for the implementation of this  
4 act.

5 SECTION 6. Effective date. This act shall take effect  
6 July 1, 1990.

7 SECTION 7. Safety clause. The general assembly hereby  
8 finds, determines, and declares that this act is necessary  
9 for the immediate preservation of the public peace, health,  
10 and safety.

BILL 5

A BILL FOR AN ACT

1 CONCERNING UNCOMPENSATED HEALTH CARE, AND MAKING AN  
2 APPROPRIATION THEREFOR.

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Bill Summary

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

Requires regulated health care professionals in active practice to provide a certain number of hours of uncompensated care annually to medically indigent persons and medicaid eligible persons as a condition of maintaining their license. Requires pharmaceutical companies and medical services supply companies to donate to medically indigent persons and medicaid eligible persons an amount of prescription drugs, supplies, and equipment equal to a certain percentage of the gross income attributable to retail sales in Colorado. Requires hospitals and nursing homes to provide free days of care to medically indigent persons and medicaid eligible persons. Authorizes the department of social services to implement a voucher system for medically indigent persons and medicaid eligible persons to receive care and for verification of participation by regulated health care professionals, pharmaceutical companies, and medical services supply companies. Allows regulated health care professionals the ability to opt-out of the uncompensated care requirement by paying three thousand dollars annually. Creates the medically indigent cash fund. Imposes a community work requirement after a person has exceeded a certain number of visits to an alcohol and drug treatment facility. Provides that if the deductible in a policy of sickness and accident insurance increases and less services are covered, the premium rate is reduced accordingly. Provides a tax deduction for regulated health care professionals who have complied with the

uncompensated care requirement. Makes an appropriation to implement the act.

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

2 SECTION 1. Title 26, Colorado Revised Statutes, 1989  
3 Repl. Vol., is amended BY THE ADDITION OF A NEW ARTICLE to  
4 read:

5 ARTICLE 16

6 Uncompensated Health Care

7 26-16-101. Short title. This article shall be known and  
8 may be cited as the "Uncompensated Health Care Act".

9 26-16-102. Legislative declaration. The general  
10 assembly finds that care of medically indigent persons and  
11 medicaid eligible persons is of vital concern for the citizens  
12 of Colorado. The general assembly further finds that the  
13 rising cost of health care is a primary factor in the  
14 increasing number of medically indigent persons and medicaid  
15 eligible persons within the state of Colorado. Therefore, the  
16 general assembly finds that a more cost-effective and  
17 efficient health care system as well as increased access for  
18 medically indigent persons and medicaid eligible persons, in  
19 accordance with this article, is necessary for the health and  
20 preservation of its citizenry.

21 26-16-103. Definitions. As used in this article, unless  
22 the context otherwise requires:

23 (1) "Assets" means cash (on hand and in the bank),  
24 stocks and securities, accounts and notes due and available to



1 the recipient, life insurance (cash value), trust funds,  
2 rental property, and real estate other than the principal  
3 residence.

4 (2) "Board" means each licensing board for the  
5 professions set out in subsection (8) of this section.

6 (3) "Documented alien" means an alien registered with  
7 the United States department of immigration and naturalization  
8 service in accordance with 8 U.S.C., section 1181.

9 (4) "High risk" means persons with high health risks or  
10 preexisting illnesses, including but not limited to heart  
11 disease, diabetes, or acquired immune deficiency syndrome  
12 (AIDS).

13 (5) "Medicaid eligible persons" means persons who are  
14 eligible for medical assistance under the "Colorado Medical  
15 Assistance Act" pursuant to article 4 of this title.

16 (6) "Medically indigent persons" means persons who are  
17 unable to pay for their medical care. The term specifically  
18 applies to those individuals and families which are either  
19 uninsured or under-insured. To qualify for eligibility, the  
20 person must be: A Colorado resident or migrant farmworker,  
21 and a United States citizen or documented alien. Eligibility  
22 criteria based upon income shall range up to one hundred fifty  
23 percent of the federal poverty level. All such persons shall  
24 be responsible to pay a portion of their bill based upon  
25 family size, income, assets, liabilities, and extraordinary  
26 expenses. Such factors shall be given equal weight in terms  
27 of ability to pay.

1           (7) "Migrant farmworker" means any individual whose  
2 principal employment is in agriculture on a seasonal basis and  
3 who establishes for the purpose of such employment a temporary  
4 abode. Migrant farmworkers are usually hired laborers who are  
5 paid piecework, hourly, or daily wages. The term includes  
6 those individuals who have been so employed within the past  
7 twenty-four months. Eligibility for service includes  
8 dependent family members of migrant farmworkers. The family  
9 members may or may not move with the migrant farmworker and  
10 establish a temporary place of abode.

11           (8) "Regulated health care professional" means any  
12 person licensed in active practice as follows: Any person  
13 licensed as a pharmacist pursuant to article 22 of title 12,  
14 C.R.S., any person licensed as a podiatrist pursuant to  
15 article 32 of title 12, C.R.S., any person licensed to  
16 practice chiropractic pursuant to article 33 of title 12,  
17 C.R.S., any person licensed as a dentist pursuant to article  
18 35 of title 12, C.R.S., any person licensed as a medical  
19 practitioner pursuant to article 36 of title 12, C.R.S., any  
20 person licensed as a nurse pursuant to article 38 of title 12,  
21 C.R.S., any person licensed as an optometrist pursuant to  
22 article 40 of title 12, C.R.S., and any professional engaged  
23 in the practice of psychotherapy, psychology, clinical social  
24 work, marriage and family therapy, professional counseling,  
25 and school psychology regulated pursuant to article 43 of  
26 title 12, C.R.S.

27           (9) "Under-insured" means individuals and families who

1 cannot afford to pay for medical costs not covered by their  
2 insurance, such as deductibles, copayments, or services not  
3 covered by an insurance policy.

4 (10) "Uninsured" means individuals and families within  
5 the following categories:

6 (a) Employed uninsured, workers who do not qualify for  
7 their employer's health plan;

8 (b) Unemployed uninsured, individuals and families which  
9 are out of the work force;

10 (c) High-risk uninsured, individuals and families with  
11 high health risks or a preexisting illness.

12 26-16-104. Applicability of article. This article and  
13 the uncompensated care requirement shall apply to all  
14 regulated health care professionals as defined in section  
15 26-16-103 (8), hospitals as defined in article 3 of title 25,  
16 C.R.S., nursing homes as regulated in article 3 of title 25,  
17 C.R.S., pharmaceutical companies, and medical services supply  
18 companies.

19 26-16-105. Voucher system. The state department of  
20 social services shall establish and implement a voucher system  
21 for medically indigent persons and medicaid eligible persons  
22 to receive health care and for verification that regulated  
23 health care professionals have fulfilled the forty-hour  
24 uncompensated care requirement and received appropriate  
25 credit. The voucher system shall also be used by medically  
26 indigent persons or medicaid eligible persons when obtaining  
27 prescription drugs, equipment, or supplies from pharmaceutical

1 companies or medical services supply companies. The state  
2 department shall approve those medically indigent persons and  
3 medicaid eligible persons who are eligible to receive care and  
4 shall give those approved persons a certified voucher which  
5 they may present to regulated health care professionals,  
6 pharmaceutical companies, or medical supply companies.

7 26-16-106. Uncompensated health care requirement for  
8 regulated health care professionals. (1) As a condition of  
9 maintaining a license issued by the applicable licensing  
10 board, regulated health care professionals in active practice  
11 shall annually provide forty hours of uncompensated care to  
12 medically indigent persons and medicaid eligible persons who  
13 have been approved by the state department of social services  
14 in accordance with section 26-16-105 and who present to the  
15 regulated health care professional a certified voucher issued  
16 by the state department. The regulated health care  
17 professional shall return any voucher which a medically  
18 indigent person or medicaid eligible person used to receive  
19 care to the state department within thirty days of care. The  
20 state department shall annually certify to the applicable  
21 licensing board when the regulated health care professional  
22 has satisfactorily provided forty hours of uncompensated care  
23 as required by this section.

24 (2) In the event that a regulated health care  
25 professional fails to complete the forty-hour requirement set  
26 forth in subsection (1) of this section, the regulated health  
27 care professional shall submit an affidavit to the board

1 explaining noncompliance and a plan to fulfill the forty-hour  
2 requirement within fifteen days after notification to the  
3 regulated health care professional by the board of  
4 noncompliance with this section.

5 (3) The plan shall be accompanied by a make-up plan  
6 filing fee, the amount of which shall be determined by the  
7 board annually, which shall be used to cover the costs of  
8 processing the plan. Such plan shall be deemed accepted by  
9 the board unless within fifteen days after the receipt of such  
10 affidavit the board notifies the regulated health care  
11 professional to the contrary.

12 (4) Failure of the regulated health care professional to  
13 comply with this section shall be grounds for suspension of  
14 licensure in accordance with the provisions for suspension of  
15 licensure by the applicable licensing board.

16 26-16-107. Opt-out provision. In lieu of providing  
17 forty hours of uncompensated care, any regulated health care  
18 professional may annually pay the sum of three thousand  
19 dollars to the state department of social services to be  
20 credited to the medically indigent cash fund. Payment of said  
21 fee shall exempt the individual regulated health care  
22 professional from the forty hours of uncompensated care as  
23 required by section 26-16-106.

24 26-16-108. Hospitals. As a condition of licensure,  
25 hospitals with up to one hundred forty-nine beds shall provide  
26 a minimum of one thousand dollars of uncompensated care for  
27 each bed per year. Hospitals with over one hundred forty-nine

1 beds shall provide the equivalent of two thousand dollars of  
2 care for each hospital bed per year. Failure to comply with  
3 this provision shall be grounds for suspension of license in  
4 accordance with section 25-3-103 (6), C.R.S.

5 26-16-109. Nursing homes. (1) As a condition of  
6 licensure, nursing homes shall provide uncompensated care as  
7 follows:

8 (a) Up to 49 beds - 100 free days of care;

9 (b) 50 to 99 beds - 200 free days of care;

10 (c) 100 to 149 beds - 300 free days of care;

11 (d) Over 149 beds - 300 free days of care plus one  
12 additional day for any beds over 149.

13 (2) Failure to comply with this provision shall be  
14 grounds for suspension of license in accordance with section  
15 25-3-103 (6), C.R.S.

16 26-16-110. Pharmaceutical companies. Pharmaceutical  
17 companies shall donate prescription drugs equal to ten percent  
18 of gross income attributable to retail sales in Colorado each  
19 year to medically indigent persons and medicaid eligible  
20 persons approved by the state department of social services in  
21 accordance with section 26-16-105. The prescription drugs  
22 shall be distributed by pharmacists through the established  
23 prescription process in accordance with article 22 of title  
24 12, C.R.S., upon receipt of a certified voucher presented by  
25 an approved medically indigent person or medicaid eligible  
26 person. The dispensing pharmacist shall be reimbursed or  
27 provided with the necessary prescription drugs by the

1 pharmaceutical company.

2       26-16-111. Medical services supply companies. Medical  
3 services supply companies that sell at retail shall donate  
4 equipment and supplies equal to ten percent of the gross  
5 income attributable to retail sales in Colorado each year to  
6 medically indigent persons and medicaid eligible persons  
7 approved by the state department of social services in  
8 accordance with section 26-16-105. The medically indigent  
9 person or medicaid eligible person shall present a certified  
10 voucher to the medical service supply company as defined in  
11 section 26-16-105.

12       26-16-112. Department of social services - powers and  
13 duties. (1) The state department of social services shall  
14 have the following powers, duties, and responsibilities for  
15 implementation of this article:

16       (a) To establish a voucher system for service to  
17 medically indigent persons and medicaid eligible persons as  
18 required by section 26-16-105;

19       (b) To establish a system and procedure for verification  
20 of participation by health care providers as required by  
21 section 26-16-104;

22       (c) To develop a system for community service  
23 requirements of medically indigent persons and medicaid  
24 eligible persons who receive care and services under this  
25 article.

26       26-16-113. Creation of medically indigent cash fund.

27 (1) The fees established in this article shall be collected

1 by the state department of social services and transmitted to  
2 the state treasurer, who shall credit the same to the  
3 medically indigent cash fund, which fund is hereby created.

4 (2) The general assembly shall make annual  
5 appropriations from the medically indigent cash fund for  
6 expenditures of the state department incurred in the  
7 performance of its duties under this article.

8 26-16-114. Obligation of medically indigent persons and  
9 medicaid eligible persons. (1) Medically indigent persons  
10 and medicaid eligible persons who receive care and services  
11 rendered under this article shall, when determined to be  
12 physically qualified, provide forty hours of health-related  
13 community services annually as a condition of maintaining  
14 their eligibility for receiving services under this article.  
15 Specific procedures and services to be rendered shall be  
16 determined by the state department, in accordance with section  
17 26-16-112.

18 (2) Failure of a medically indigent person or medicaid  
19 eligible person who receives care and services to render the  
20 forty hours of health-related community services shall  
21 disqualify such person from receiving health care services  
22 under this article for a period of one year, to commence  
23 immediately following disqualification.

24 SECTION 2. 12-22-116, Colorado Revised Statutes, 1985  
25 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW  
26 SUBSECTION to read:

27 12-22-116. Licensure or registrations - applicability -



1 applications. (8) As a condition of maintaining a license  
2 issued under this article, pharmacists shall annually provide  
3 forty hours of uncompensated care to medically indigent  
4 persons and medicaid eligible persons, in accordance with  
5 section 26-16-106, C.R.S.

6 SECTION 3. 12-22-125 (2) (a), Colorado Revised Statutes,  
7 1985 Repl. Vol., as amended, is amended BY THE ADDITION OF A  
8 NEW SUBPARAGRAPH to read:

9 12-22-125. Licenses or registrations may be denied,  
10 suspended, or revoked. (2) (a) (VI) Has failed to annually  
11 provide forty hours of uncompensated care to medically  
12 indigent persons and medicaid eligible persons, in accordance  
13 with sections 12-22-116 (8) and 26-16-106, C.R.S.

14 SECTION 4. 12-32-105, Colorado Revised Statutes, 1985  
15 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to  
16 read:

17 12-32-105. Examination as to qualifications. (3) As a  
18 condition of maintaining a license issued under this article,  
19 podiatrists shall annually provide forty hours of  
20 uncompensated care to medically indigent persons and medicaid  
21 eligible persons, in accordance with section 26-16-106, C.R.S.

22 SECTION 5. 12-32-107 (3), Colorado Revised Statutes,  
23 1985 Repl. Vol., as amended, is amended BY THE ADDITION OF A  
24 NEW PARAGRAPH to read:

25 12-32-107. Issuance, revocation, or suspension of  
26 license - probation - immunity in professional review.  
27 (3) Failure to annually provide forty hours of uncompensated

1 care to medically indigent persons and medicaid eligible  
2 persons, in accordance with sections 12-32-105 (3) and  
3 26-16-106, C.R.S.

4 SECTION 6. 12-33-114, Colorado Revised Statutes, 1985  
5 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to  
6 read:

7 12-33-114. Renewal of license. (3) As a condition of  
8 maintaining a license issued under this article, chiropractors  
9 shall annually provide forty hours of uncompensated care to  
10 medically indigent persons and medicaid eligible persons, in  
11 accordance with section 26-16-106, C.R.S.

12 SECTION 7. 12-33-117 (2), Colorado Revised Statutes,  
13 1985 Repl. Vol., as amended, is amended BY THE ADDITION OF A  
14 NEW PARAGRAPH to read:

15 12-33-117. Suspension or revocation of license.  
16 (2) Failure to annually provide forty hours of uncompensated  
17 care to medically indigent persons and medicaid eligible  
18 persons, in accordance with sections 12-33-114 (3) and  
19 26-16-106, C.R.S.

20 SECTION 8. 12-35-116, Colorado Revised Statutes, 1985  
21 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW  
22 SUBSECTION to read:

23 12-35-116. Renewal of license - fees. (3) As a  
24 condition of maintaining a license issued under this article,  
25 dentists shall annually provide forty hours of uncompensated  
26 care to medically indigent persons and medicaid eligible  
27 persons, in accordance with section 26-16-106, C.R.S.

1 SECTION 9. 12-35-117, Colorado Revised Statutes, 1985  
2 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW  
3 SUBSECTION to read:

4 12-35-117. Failure to renew license - forfeiture -  
5 effect on disciplinary proceedings. (3) Failure to annually  
6 provide forty hours of uncompensated care to medically  
7 indigent persons and medicaid eligible persons, in accordance  
8 with sections 12-35-116 (3) and 26-16-106, C.R.S., shall be  
9 grounds for suspension of license under this article.

10 SECTION 10. 12-36-107, Colorado Revised Statutes, 1985  
11 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to  
12 read:

13 12-36-107. Qualifications for licensure. (5) As a  
14 condition of maintaining a license issued under this article,  
15 physicians shall annually provide forty hours of uncompensated  
16 care to medically indigent persons and medicaid eligible  
17 persons, in accordance with section 26-16-106, C.R.S.

18 SECTION 11. Article 36 of title 12, Colorado Revised  
19 Statutes, 1985 Repl. Vol., as amended, is amended BY THE  
20 ADDITION OF A NEW SECTION to read:

21 12-36-107.3. Suspension of license. Failure to annually  
22 provide forty hours of uncompensated care to medically  
23 indigent persons and medicaid eligible persons, in accordance  
24 with sections 12-36-107 (5) and 26-16-106, C.R.S., shall be  
25 grounds for suspension of license.

26 SECTION 12. 12-38-111, Colorado Revised Statutes, 1985  
27 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to

1 read:

2 12-38-111. Requirements for professional nurse  
3 licensure. (3) As a condition of maintaining a license  
4 issued under this article, nurses shall annually provide forty  
5 hours of uncompensated care to medically indigent persons and  
6 medicaid eligible persons, in accordance with section  
7 26-16-106, C.R.S.

8 SECTION 13. Article 38 of title 12, Colorado Revised  
9 Statutes, 1985 Repl. Vol., as amended, is amended BY THE  
10 ADDITION OF A NEW SECTION to read:

11 12-38-111.5. Suspension of license. Failure to annually  
12 provide forty hours of uncompensated care to medically  
13 indigent persons and medicaid eligible persons, in accordance  
14 with section 12-38-111 (3), 12-38-112 (3), and 26-16-106,  
15 C.R.S., shall be grounds for suspension of license.

16 SECTION 14. 12-38-112, Colorado Revised Statutes, 1985  
17 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to  
18 read:

19 12-38-112. Requirements for practical nurse licensure.  
20 (3) As a condition of maintaining a license issued under this  
21 article, nurses shall annually provide forty hours of  
22 uncompensated care to medically indigent persons and medicaid  
23 eligible persons, in accordance with section 26-16-106, C.R.S.

24 SECTION 15. 12-40-113, Colorado Revised Statutes, 1985  
25 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to  
26 read:

27 12-40-113. License renewal - requirements - fee, failure

1 to pay. (3) As a condition of maintaining a license issued  
2 under this article, optometrists shall annually provide forty  
3 hours of uncompensated care to medically indigent persons and  
4 medicaid eligible persons, in accordance with section  
5 26-16-106, C.R.S.

6 SECTION 16. 12-40-119, Colorado Revised Statutes, 1985  
7 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW  
8 SUBSECTION to read:

9 12-40-119. Revocation, suspension, supervision,  
10 probation procedure - professional review. (4) Failure to  
11 annually provide forty hours of uncompensated care to  
12 medically indigent persons and medicaid eligible persons, in  
13 accordance with sections 12-40-113 (3) and 26-16-106, C.R.S.,  
14 shall be grounds for suspension of license.

15 SECTION 17. 12-43-212, Colorado Revised Statutes, 1985  
16 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW  
17 SUBSECTION to read:

18 12-43-212. Denial of license - renewal. (5) As a  
19 condition of maintaining a license issued under this article,  
20 or a certificate as a school psychologist regulated pursuant  
21 to this article, licensees and certified school psychologists  
22 shall annually provide forty hours of uncompensated care to  
23 medically indigent persons and medicaid eligible persons, in  
24 accordance with section 26-16-106, C.R.S.

25 SECTION 18. Part 2 of article 43 of title 12, Colorado  
26 Revised Statutes, 1985 Repl. Vol., as amended, is amended BY  
27 THE ADDITION OF A NEW SECTION to read:

1           12-43-212.5. Suspension of license. Failure to annually  
2 provide forty hours of uncompensated care to medically  
3 indigent persons and medicaid eligible persons, in accordance  
4 with sections 12-43-212 (5) and 26-16-106, C.R.S., shall be  
5 grounds for suspension of license.

6           SECTION 19. 25-3-102, Colorado Revised Statutes, 1989  
7 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to  
8 read:

9           25-3-102. License - application - issuance. (3) As a  
10 condition of renewing a license issued under this article,  
11 hospitals and nursing homes shall annually provide a specified  
12 number of free days of care to medically indigent persons and  
13 medicaid eligible persons, in accordance with sections  
14 26-16-108 and 26-16-109, C.R.S.

15           SECTION 20. 25-3-103, Colorado Revised Statutes, 1989  
16 Repl. Vol., is amended BY THE ADDITION OF A NEW SUBSECTION to  
17 read:

18           25-3-103. License denial or revocation - provisional  
19 license. (6) Failure to annually provide care for medically  
20 indigent persons and medicaid eligible persons, as specified  
21 in sections 26-16-108 and 26-16-109, C.R.S., shall be grounds  
22 for suspension of license.

23           SECTION 21. 25-1-307 (1), Colorado Revised Statutes,  
24 1989 Repl. Vol., is amended BY THE ADDITION OF A NEW PARAGRAPH  
25 to read:

26           25-1-307. Acceptance for treatment - rules.  
27 (1) (f) Alcoholics and intoxicated persons admitted to an

1 approved treatment facility shall be limited to ten visits per  
2 year and shall be subject to a work and treatment program  
3 established by the treatment facility administrator.

4 SECTION 22. Part 1 of article 8 of title 10, Colorado  
5 Revised Statutes, 1987 Repl. Vol., as amended, is amended BY  
6 THE ADDITION OF A NEW SECTION to read:

7 10-8-126. Actuarial considerations in rate reductions  
8 for sickness and accident insurance premiums. (1) On and  
9 after January 1, 1991, any filing with the commissioner  
10 pursuant to section 10-8-102 of the premium rate and  
11 classification of risks pertaining to any policy of sickness  
12 and accident insurance delivered or issued for delivery in  
13 this state shall include a reduction based on savings in the  
14 cost of such insurance resulting from the implementation of  
15 the provisions of article 16 of title 26, C.R.S.

16 (2) If the deductible amount in any provision of a  
17 policy of sickness and accident insurance delivered or issued  
18 for delivery in this state pursuant to this article is  
19 increased at any time, the premium rate for such policy of  
20 sickness and accident insurance shall be reduced accordingly  
21 in a filing with the commissioner pursuant to section 10-8-102  
22 to reflect the reduction in coverage represented by such  
23 increased deductible amount.

24 SECTION 23. 39-22-104 (4), Colorado Revised Statutes,  
25 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A  
26 NEW PARAGRAPH to read:

27 39-22-104. Income tax imposed on individuals, estates,

1 and trusts - single rate. (4) (h) The amount of five  
2 thousand dollars, in the case of regulated health care  
3 professionals, as defined in section 26-16-103 (8), C.R.S.,  
4 who have complied with the uncompensated care requirement of  
5 section 26-16-106, C.R.S., during the taxable year.

6 SECTION 24. Appropriation. (1) In addition to any  
7 other appropriation, there is hereby appropriated, out of any  
8 moneys in the general fund not otherwise appropriated, to the  
9 department of social services, for the fiscal year beginning  
10 July 1, 1990, the sum of \_\_\_\_\_ dollars (\$ \_\_\_\_\_), or so  
11 much thereof as may be necessary, for the implementation of  
12 this act.

13 (2) In addition to any other appropriation, there is  
14 hereby appropriated, out of any moneys in the general fund not  
15 otherwise appropriated, to the department of health, for the  
16 fiscal year beginning July 1, 1990, the sum of \_\_\_\_\_  
17 dollars (\$ \_\_\_\_\_), or so much thereof as may be necessary,  
18 for the implementation of this act.

19 SECTION 25. Effective date. This act shall take effect  
20 July 1, 1990.

21 SECTION 26. Safety clause. The general assembly hereby  
22 finds, determines, and declares that this act is necessary  
23 for the immediate preservation of the public peace, health,  
24 and safety.



BILL 6

A BILL FOR AN ACT

1 CONCERNING THE PROVISION OF HEALTH INSURANCE FOR FIFTEEN OR  
2 FEWER EMPLOYEES AS AN ALTERNATIVE TO COVERAGE UNDER THE  
3 "WORKMEN'S COMPENSATION ACT OF COLORADO".

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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 employers may offer health insurance in lieu of coverage under the "Workmen's Compensation Act of Colorado" and retain the same immunity from liability as employers providing coverage under said act, if the concerned employee is advised of the benefits available under each alternative and chooses to accept the health insurance and waive his rights under the "Workmen's Compensation Act of Colorado".

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

5 SECTION 1. Article 41 of title 8, Colorado Revised  
6 Statutes, 1986 Repl. Vol., as amended, is amended BY THE  
7 ADDITION OF A NEW SECTION to read:

8 8-41-107.5. Not applicable to certain employers.

9 (1) Notwithstanding any other provision of law to the  
10 contrary, the provisions of articles 40 to 54 of this title

1    except for section 8-42-102 shall not apply to an employer  
2    with respect to an individual employee if the following  
3    conditions are met:

4           (a) The employer offers the employee sickness and  
5    accident or health insurance and the specifications of such  
6    insurance, including the amount of any deductible, meet or  
7    exceed the specifications for the health insurance plan  
8    prepared by the state personnel director pursuant to sections  
9    10-8-205 (1) (a) and 10-8-206, C.R.S.; and

10           (b) The employee has been fully advised of the benefits  
11    available to him under the "Workmen's Compensation Act of  
12    Colorado" and those that would instead be available to him  
13    under the health insurance described in paragraph (a) of this  
14    subsection (1), the employee chooses to accept such health  
15    insurance in lieu of coverage under said act, and the employee  
16    waives his rights under the "Workmen's Compensation Act of  
17    Colorado".

18           SECTION 2. Safety clause. The general assembly hereby  
19    finds, determines, and declares that this act is necessary  
20    for the immediate preservation of the public peace, health,  
21    and safety.