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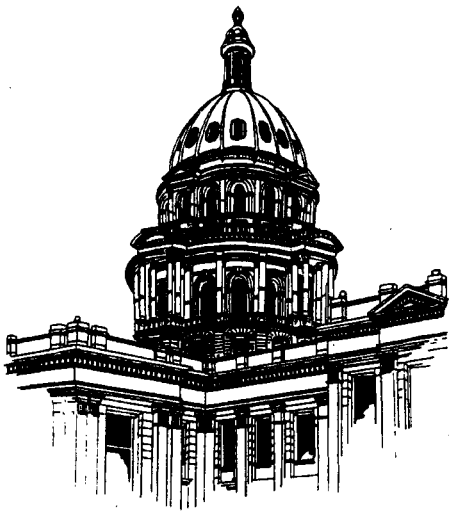
0494 Health Care Needs

Colorado Legislative Council

0494 Health Care Needs



Task Force to Evaluate Health Care Needs

Report to the

COLORADO

GENERAL ASSEMBLY

Colorado Legislative Council
Research Publication No. 494
December 2001

RECOMMENDATIONS FOR 2002

TASK FORCE TO EVALUATE HEALTH CARE NEEDS

Report to the
Colorado General Assembly

Research Publication No. 494
December 2001

COLORADO GENERAL ASSEMBLY

LEGISLATIVE COUNCIL

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December 2001

To Members of the Sixty-third General Assembly:

Submitted herewith is the final report of the Task Force to Evaluate Health Care Needs. This committee was created pursuant to Section 26-2-722, Colorado Revised Statutes. The purpose of the committee is to oversee the Colorado Works Program and its implementation by the counties.

At its meeting on November 15, 2001, the Legislative Council reviewed the report of this committee. A motion to forward this report and the bills therein for consideration in the 2002 session was approved.

Respectfully submitted,

/s/ Senator Stan Matsunaka
Chairman
Legislative Council

SM/JG/kd

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RECOMMENDED BILLS AND FISCAL NOTES

Task Force to Evaluate Health Care Needs for Colorado

Members of the Committee

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Chairman
Senator Bob Hagedorn
Senator Jim Isgar
Senator Andy McElhany
Senator Dave Owen

Representative Lola Spradley,
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Executive Summary

Committee Charge

The Task Force to Evaluate Health Care Needs was created pursuant to Senate Bill 01-224 and charged with studying and evaluating health care insurance issues affecting the small group market, access to health care services and health insurance in rural areas, and the cost factors driving health insurance premiums. Specifically, the committee was required to review, at a minimum, the following issues regarding the cost and access of health insurance:

- how the relationship between health care providers and carriers is affecting access to and costs of health insurance coverage, particularly in rural areas;
- the general cost factors driving the rising health insurance premium rates for consumers of health insurance in all markets, as affected by small group health insurance laws;
- how to create greater choice of health care plans for all small businesses at more affordable rates;
- how more affordable access to and greater choice of health care services for all small employers may be improved;
- how more affordable access to and greater choice of health care services may be improved through competition;
- the extent to which the "Small Employer Health Insurance Availability Program Act" and other state legislation, and the federal "Health Insurance Portability and Accountability Act of 1996" impacted the small group market;
- how Colorado can recruit and retain health care professionals to rural and urban Colorado;
- how self-funded health insurance plans may create an alternative to meet health care needs;
- the influence the state has as a large employer in the health insurance market and the feasibility of enrolling state employees into PERACare as an alternative to existing health benefit plans being offered to state employees; and
- the general cost factors involved in prescription drug benefits.

Committee Activities

The committee held a total of eight meetings, six of which were in rural Colorado (Trinidad, Sterling, Leadville, Montrose, Durango, and Kremmling). Priority at these meetings was given to public testimony to allow citizens in the region the opportunity to

voice their concerns and suggestions surrounding health care insurance and services in rural Colorado. The committee also considered testimony from insurance carriers, a wide range of health care providers, small employers, pharmacists, state employees, PERA, the Department of Regulatory Agencies - Division of Insurance, and the Department of Personnel/General Support Services at these meetings.

Many common issues emerged at these meetings, most notably the lack of affordable health insurance options for rural citizens. Other common issues raised were the need for medical specialists and nursing personnel in rural areas, the increasing rate of charity care and delinquent accounts for health care providers, problems with timely insurance payments to providers, cost shifting, low reimbursement rates from insurance carriers to health care providers and pharmacists, low Medicaid/Medicare reimbursement rates, and the lack of network adequacy in rural areas.

Committee Recommendations

As a result of committee discussion and deliberation, the committee recommends nine bills and one concurrent resolution for consideration in the 2002 legislative session.

Bill A — Creation of a Loan Program for Nurses. The bill authorizes new student loans for qualified students at approved nursing programs. Loan amounts are limited to $1,000 annually and to no more than $2,000 in total. The bill also establishes repayment requirements.

Bill B — Creation of an Advisory Committee to Study the Administration of Medications by Certified Nurse Aides. The bill requires the State Board of Nursing in the Department of Regulatory Agencies, together with the Health Facilities Regulation Division in the Department of Public Health and Environment, to appoint a ten-member advisory committee to study the administration of medications by certified nurse aides in long-term care facilities. The bill identifies committee composition, study requirements, and reporting requirements. The advisory committee is repealed December 31, 2002.

Bill C — Credit Against the Colorado Income Tax for Health Care Professionals Practicing in Rural Health Care Professional Shortage Areas. The bill makes the existing personal income tax credit for health care professionals practicing in rural health care professional shortage areas a permanent tax credit that shall be allowed on or after January 1, 2002, but prior to January 1, 2011. Additionally, for tax years beginning on and after January 1, 2003, the tax credit is expanded to include registered nurses, licensed practical nurses, medical technicians, and pharmacists.

Bill D — Guaranteed Issue of Health Insurance Benefits for Business Groups of One. The bill eliminates the requirement that a business group of one work 24 hours per week in order to qualify as such. The bill clarifies that carriers offering health benefit coverage to small employers may reduce benefits by 50 percent for business groups of one for up to 12 months.

Bill E — Proportional Rating for Health Insurance Premiums for Business Groups of One. The bill authorizes a proportional rating model using health screening for business groups of one and allows: (1) an increase or decrease of up to 15 percent of the carrier's filed rate based on claims experience, health status, or duration of coverage; (2) premium increases of up to 10 percent annually based on such factors; and (3) an overall rate change of no more than 5 percent of the modified community rating filed with the Commissioner of Insurance. Additionally, the bill establishes reporting requirements for small group carriers.

Bill F — Submitting to the Registered Electors of the State of Colorado an Amendment to Section 2 of Article XI of the Constitution of the State of Colorado, Concerning the Authorization for Local Governments that are Lawfully Authorized to Provide Health Care to Participate with a Public or Private Entity in Affecting the Provision of Such Health Care, and, in Connection Therewith, Authorizing a County, City, Town, Township, or Special District to Become a Subscriber, Member, or Shareholder in or a Joint Owner with any Person or Company, Public or Private, in Order to Provide Such Health Care Without Incurring Debt and Without Pledging its Credit or Faith; Requiring any Such County, City, Town, Township, or Special District Entering Such an Arrangement to Own its Just Proportion to the Whole Amount Invested; and Providing that any Such Entity or Relationship Established for Such Purpose Shall not be Deemed a Political Subdivision, Local Government, or Local Public Body for any Purpose. The concurrent resolution allows any local government entity authorized to provide health care functions, services, or facilities to be joint owner with, shareholder in, or members of any public or private entity in order to perform such functions, services, or facilities. Local government entities are prohibited from incurring debt or pledging their credit or faith under such arrangements and are required to own their just proportion when entering into such arrangements. Any private entity or relationship established for such purpose shall not be deemed a political subdivision, local government, or local public body for such purpose.

Bill G — Definition of Basic Health Benefit Coverage. The bill clarifies the definition of a basic health benefit plan for a small employer group and exempts such plans from certain mandatory coverage provisions.

Bill H — Prompt Payment of Health Insurance Claims. The bill requires the Commission of Insurance to adopt uniform health care claim forms and standardized billing codes to be used by all health care providers by July 1, 2002. Insurance companies are required to: (1) accept uniform health insurance claim forms from health care providers in electronic form by October 1, 2002; (2) provide acknowledgment to an insured or health care provider upon receipt of a claim; and (3) notify a claimant within 30 days after receipt of a claim when it is held due to delinquent premiums. The bill establishes time frames for claims to be paid, denied, or settled, and establishes penalties for noncompliance.

Bill I — Limitation of Contingency Fee Agreements in Medical Malpractice Actions. The bill limits an attorney's contingency fee for medical malpractice actions filed to no more than 20 percent of the settlement amount. Damages received for past, current

and future medical expenses shall not be included in determining the amount of damages subject to the 20 percent contingency fee. The court may award or approve a contingency fee or other fee in excess of 20 percent if it determines that the attorney has devoted an extraordinary amount of time to the case.

Bill J — Expanded Access to Health Insurance. The bill allows a health insurance carrier to cross state lines to comply with existing requirements for network adequacy. Additionally, health maintenance organizations (HMOs) are authorized to offer coverage to persons residing outside the HMO's geographic service area.

Statutory Authority and Responsibilities

Pursuant to Senate Bill 01-224, the Task Force to Evaluate Health Care Needs was charged with studying and evaluating health care insurance issues affecting the small group market, access to health care services and health insurance in rural areas, and the cost factors driving health insurance premiums. The task force was authorized to make recommendations regarding these issues, and if necessary, to sponsor legislation. The committee consisted of ten members, five from the House of Representatives and five from the Senate. The committee was required to hold a total of eight meetings, six of which in rural Colorado.

Committee Activities

The committee held a total of eight meetings, six of which were in rural Colorado (Trinidad, Sterling, Leadville, Montrose, Durango, and Kremmling). Priority at these meetings was given to public testimony to allow citizens the opportunity to voice their concerns and make suggestions regarding rural health care services. The committee also considered testimony from state agencies, insurance providers, a wide range of health care providers, small employers, pharmacists, and state employees. The following sections capture the major highlights of committee testimony and discussion.

Primary Concerns

Citizens are concerned about the lack affordability and the decreasing number of options for health care coverage in rural communities. Because of rising costs and a lack of network adequacy, insurance carriers are pulling out of the rural market. The lack of rural specialists also precludes some insurance companies from entering or remaining in rural communities. For some rural citizens, fewer carriers has contributed to the loss of employer-based insurance. In order to retain coverage, rural citizens are paying a significant portion of their incomes to retain coverage. Costs are being driven upward by:

- excessive paperwork;
- the high cost of malpractice insurance;
- smaller populations that result in higher per-patient, per-visit costs;
- cost shifting resulting from lower reimbursements for Medicare and Medicaid patients;
- a disproportionate number of women, children, and elderly citizens who are under- or un-insured;
- the overuse/misuse of the health care system by individuals with/without insurance; and
- the rising cost of pharmaceuticals and increased use of new, designer drugs.

A wide range of health care providers made suggestions to reduce rising costs. Some changes must occur at the national level, but locally, changes that could reduce premiums include:

- increased co-pays; and
- increased personal responsibility and preventative practices.

Medical Professional Shortage

One factor that limits the quality and availability of rural health care services is the shortage of health care professionals. Aside from physicians and dentists, the shortage includes physician assistants, nurses, certified nursing assistants (CNAs), respiratory therapists, radiologists, and licensed nursing home administrators. Currently, the nursing shortage is particularly severe.

In rural communities, low pay, isolation, and long working hours are all contributing to the medical professional shortage. Generally, rural medical professionals make less than their urban counterparts and work more hours due to fewer providers. Some suggestions for recruiting and retaining more rural professionals include tax incentives and modifications to admission requirements for medical school to allow more rural candidates to be admitted. Other suggestions included:

- policies that offer housing grants;
- policies that reimburse nurse practitioners and physician assistants at the same rate as physicians when providing the same service; and
- policies that reimburse CNAs for mileage and other benefits.

Health Care Provider Issues

A coalition of providers presented suggestions to reduce their costs and make the delivery of health care services more efficient. Testimony indicated that simplifying insurance plans would allow the public to more easily understand the benefits of their insurance plan. Providers could also benefit from standardized regulations that streamline the authorization process. Other suggestions include the implementation of policies that:

- integrate telemedicine into the health care system;
- reduce the number of Medicare and Medicaid regulations;
- will not discourage specialists from providing service to Medicaid patients; and
- assist hospitals in recruiting specialists.

Rural Hospitals

The committee toured two small (less than 50 beds), rural hospitals: Saint Vincent's General Hospital in Leadville and the Kremmling Memorial Hospital in Kremmling, Colorado. Hospital administrators discussed the difficulties of day-to-day operations, including the recruitment of specialists and operating efficiently given the complexity of insurance companies and reimbursement rates. Administrators discussed how:

- Colorado's Medicaid reimbursement rates are lower than other states;
- hospitals are having to increase the amount of charity care they provide;
- the overuse of hospital emergency care results in increased debt; and
- the lack of urgent care facilities results in more hospital stays.

State Employee Issues

The Department of Personnel/General Support Services informed the committee that the state is experiencing premium increases ranging between 25 to 40 percent for 2002. Even greater increases will occur for carriers who provide service to Pueblo County state employees. Insurance coverage options for state employees in other rural communities is often limited to one provider, and coverage is expensive. As a result, the state is having a difficult time recruiting and retaining rural area

employees. Wages in these areas trend to be low, and the benefits offered by the state are no longer as attractive as those offered by other employers.

Children's Health Issues

The committee's discussion of children's health issues focused on the lack of providers and poor access to dental care. Because of low reimbursement rates, there are an insufficient number of physicians willing to participate in the Children's Health Insurance Plan (CHIP). The committee also learned that children in rural communities have poor access to primary dental care. One solution may be to increase the role of community nurses who could promote the need and importance of good dental hygiene. Another suggestion is to offer dental care to children enrolled in Medicaid.

Small Group Market/Business Group of One

Rising insurance costs are also making employer-sponsored health insurance unaffordable for employers and employees. This results in more uninsured individuals and families. Small business owners would like more options for catastrophic coverage for their employees.

Another problem is that business group of one coverage is becoming a safety net. Self-employed individuals are opting into business group of one coverage only once a medical problem arises. After the problem has been dealt with, many individuals drop their coverage. This results in overuse of the plan and higher costs for those individuals who remain in the plan when they are healthy. The committee discussed how limiting benefits during the first 12 months of coverage might lower costs and encourage individuals to remain in the plan when healthy. Another option discussed was legislation that would allow carriers to adjust their rates based on previous claims and health status.

SUMMARY OF RECOMMENDATIONS

As a result of committee discussion and deliberation, the committee recommends the following bills for consideration during the 2002 legislative session.

Bill A — Concerning the Creation of a Loan Program for Nurses

This bill makes a legislative declaration regarding the Colorado nurse shortage and establishes a nursing student loan program. Beginning January 1, 2003, student loans shall be made to at least one qualified student at each approved nursing program in the state. Qualifying students shall be residents of Colorado, shall agree to practice nursing in Colorado for the equivalent of one year of full-time practice for each year a loan is received and shall demonstrate a financial need. The loan amounts are limited to no more than $1,000 per academic year and no more than $2,000 total. The bill provides for loan repayment if the student discontinues the nursing program or does not engage in full-time practice for the required amount of time. If the student completes the service requirement, the loan is forgiven. The bill establishes the nursing student loan cash fund to receive loan repayments and any gifts, grants, or donations to the program. The bill is effective July 1st (year unspecified in the bill) and contains a safety clause.

Bill B — Concerning the Creation of an Advisory Committee to Study the Administration of Medications by Certified Nurse Aides

This bill establishes a ten member public advisory committee to study the administration of medications by certified nurse aides in long-term care facilities and by home health care providers. The study shall include a) the benefits and risks associated with training certified nurse aides to become medication aides; b) the effect of the use of medication aides on the level of patient care; c) the level of experience a certified nurse aide must have in order to be considered for training as a medication aide; d) the extent and content of classroom training and education required to be a medication aide; and e) the extent and limit to the scope of practice of a certified aide who has completed training as a medication aide. The advisory committee is appointed by the State Board of Nursing Aides in conjunction with the Health Facilities Regulation Division in the Department of Public Health and Environment. The advisory committee shall report their findings and recommendations no later than April 15, 2002, and is repealed on December 31, 2002. The bill contains a safety clause.

Bill C — Concerning the Credit Against the Colorado Income Tax for Health Care Professionals Practicing in Rural Healthcare Professional Shortage Areas

This bill makes the existing personal income tax credit for health care professionals practicing in a rural health care professional shortage area a permanent tax credit that is not subject to certification by the State Controller that there are excess revenues exceeding the TABOR expenditure limits. For tax years beginning on and after January 1, 2003, the bill expands the tax credit by making

registered nurses, licensed practical nurses, medical technicians and pharmacists eligible for the tax credit.

Bill D — Concerning the Guaranteed Issue of Health Insurance Benefits for Business Groups of One

This bill eliminates the requirement that a business group of one work 24 hours per week in order to qualify as a business group of one. The bill also eliminates provisions in statute restricting open enrollment periods for business groups of one to the 31 day period after the birth date of the person qualifying as a business group of one and provides that a small employer carrier may offer a basic or standard plan to a business group of one that reduces the amount of benefits covered by 50 percent for the first twelve months of coverage from the date of application as a business group of one. The bill has an effective date of January 1, 2003.

Bill E — Concerning Proportional Rating for Health Insurance Premiums for Business Groups of One

This bill provides that after January 1, 2003, small group health benefit plans issued or renewed to a business group of one may have rates adjustments based on the claims experience, health status, or duration of coverage. Any rate adjustments for these reasons shall not be charged to the individuals under the plan, shall not result in a rate for the small employer that deviates more than 15 percent from the carrier's filed rate, and shall be applied uniformly to the rates charged for all individuals under the business group of one policy. The bill also provides that the business group of one's annual renewal premium rate adjustment shall not exceed 10 percent. The bill requires small group carriers to file semiannual reports to the Commission of Insurance (Commissioner) enabling the Commissioner to monitor the relationship of the aggregate adjusted premiums actually charged to policyholders to the premiums that would have been charged by application of the carrier's modified community rates. If the premium exceeds the average modified community rate by more than 5 percent, the carrier must adjust the premiums downward to the 5 percent limit. After January 1, 2004, small employer carriers shall demonstrate that a certain percentage (unspecified in the draft) of business groups of one are at or below the filed community index rate. Such decreases shall continue until such small employer carriers demonstrate that at least 80 percent of the business groups of one are at or below the filed community index rate.

Bill F — Submitting to the Registered Electors of the State of Colorado an Amendment to Section 2 of Article XI of the Constitution of the State of Colorado, Concerning the Authorization for Local Governments that are Lawfully Authorized to Provide Health Care to Participate with a Public or Private Entity in Affecting the Provision of Such Health Care, and, in Connection Therewith, Authorizing a County, City, Town, Township, or Special District to Become a Subscriber, Member, or Shareholder in or a Joint Owner with Any Person or Company, Public or Private, in Order to Provide Such Health Care Without Incurring Debt and Without Pledging its Credit or Faith; Requiring Any Such County, City, Town, Township, or Special District Entering Such an Arrangement to Own its Just Proportion to the Whole Amount Invested; and

Providing that Any Such Entity or Relationship Established for Such Purpose Shall Not Be Deemed a Political Subdivision, Local Government, or Local Public Body for any Purpose

This concurrent resolution submits to the voters at the next general election an amendment to the Colorado Constitution allowing any local government entity authorized to provide health care functions, services, or facilities to be joint owners with, shareholders in, or members of any public or private entity in order to provide such functions, services, or facilities. The local government entity is prohibited from incurring debt or pledging its credit or faith in such an arrangement and the local government entity is required to own its just proportion when entering into such an arrangement. The concurrent resolution specifies that any private entity or relationship established for such purpose shall not be deemed a political subdivision, local government, or local public body.

Bill G — Concerning the Definition of Basic Health Benefit Coverage

This bill codifies that the rules for small employer health insurance plans shall include that 1) standard health benefit plans reflect the benefit design of common plan offerings in the small group market and 2) basic health benefit plans reflect the benefit design of catastrophic coverage except that a health maintenance organization (HMO) basic health benefit plans reflect a sharing of higher consumer costs through higher co-payments instead of deductible amounts. The bill provides that basic health benefit plans do not have to provide mandatory coverage for newborn children; physical, occupation, and speech therapy care and treatment of congenital defects and birth abnormalities; low-dose mammography; mental illness; biologically-based mental illness; hospice care coverage; alcoholism; prostate cancer screening; hospitalization and general anesthesia for dental procedures for dependent children; diabetes; or prosthetic devices. The bill has an effective date of January 1, 2003.

Bill H — Concerning Prompt Payment of Health Insurance Claims

This bill requires the Commissioner of Insurance (Commissioner) to adopt uniform health care claim forms and standardized billing codes to be used by all health care providers in the state by July 1, 2002. The bill requires all insurance companies to accept uniform health insurance claim forms from health care providers in electronic form by October 1, 2002, and requires all insurance companies to provide an acknowledgment to an insured or a health care provider upon receipt of a claim. Insurance companies shall notify a claimant within 30 days after receipt of a claim when the claim is held due to delinquent premiums and all electronic health insurance claims shall be paid, denied, or settled within 78 days after initial receipt by the carrier. In cases where an insurer fails to comply with these requirements, the bill establishes a penalty of 10 percent of the total amount ultimately allowed on the claim. An additional penalty equal to 20 percent of a claim shall be charged to any insurer who demonstrates a pattern of noncompliance with these requirements. The bill contains a safety clause.

Bill I — Concerning the Limitation of Contingency Fee Agreements in Medical Malpractice Actions

This bill limits an attorney's contingency fee for medical malpractice actions filed on or after August 15, 2002, to no more than 20 percent of the settlement amount. Damages received for past medical expenses, medical expenses being paid and future medical expenses are excluded from the damages subject to the 20 percent limitation. A court may award or approve a contingency fee or other fee in a percentage higher than the 20 percent limitation if the court finds the attorney devoted an extraordinary amount of time to the case. The bill requires attorneys to provide in writing to their medical malpractice clients the attorney's fees and other expenses and charges that the attorney may undertake on behalf of the client's case. The bill has an effective date of August 15, 2002.

Bill J — Concerning Expanded Access to Health Insurance

This bill allows a health insurance carrier to cross state lines to comply with existing requirements for network adequacy. The bill allows a health maintenance organization (HMO) to offer health insurance coverage for persons who reside outside of the HMO's geographic service area provided that the HMO provides a disclosure to the small employer and its employees who purchase health insurance coverage under these circumstances. The bill has an effective date of January 1, 2003.

Resource Materials

The resource materials listed below were provided to the committee or developed by Legislative Council staff during the course of the meetings. The summaries of meetings and attachments are available at the Division of Archives, 1313 Sherman Street, Denver, (303) 866-2055. For a limited time, the meeting summaries and materials developed by Legislative Council Staff are available on our web site at:

www. state.co.us/gov_dir/leg_dir/lcsstaff/2001/01interim.

Meeting Summaries	Topics Discussed
July 21, 2001	An overview of health insurance in Colorado, health care coverage and availability in southern Colorado, the consumer's perspective in southern Colorado; and public testimony.
August 7, 2001	Public testimony; testimony from health care providers in northeastern Colorado; information on recruiting health care professionals to rural Colorado; and testimony on PERACare and the state's influence in the health insurance market.
August 27, 2001	Public testimony; information on small employer health insurance availability; overview of individual insurance providers; and testimony from the Colorado State Association of Health Underwriters.
September 4, 2001	Public testimony and testimony from insurance providers serving rural Colorado.
September 5, 2001	Testimony from rural hospitals, specifically Medicaid and administrative difficulties; information on Colorado's nursing shortage; testimony from independent health care providers; discussion on telemedicine and alternative medicine; testimony from the rural employers; and public testimony.
September 7, 2001	Presentation on the University of Colorado Health Sciences Center; discussion on the implementation of prenatal care for undocumented women and dental services for children on Medicaid; discussion on the lack of providers for the Children's Basic Health Plan; testimony on small group health insurance reform and insurance mandates; and an overview of the national perspective on rural health care.
September 12, 2001	Public testimony; presentation on rural health networks; discussion on rural hospital services; and an overview of the cost factors involved in prescription drug benefits.

September 26, 2001	Discussion of health care benefits for rural state employees; presentation on business group of one health care coverage; presentation on individual practice associations; and committee discussion on bill proposals.

Memoranda and Reports

Reports provided to the committee:

Small Group Health Insurance Reform - Report to the Colorado Legislature, Senate Bill 99-124, University of Northern Colorado, December 1, 1999.

Special Session Health Care Issues, Department of Personnel and General Support Services, September 19, 2001.

Comparison of Colorado's Small Group Laws and The Health Insurance Portability and Accountability Act (HIPAA), Colorado Division of Insurance, September 20, 2001.

Impacts of Repealing Substantive Provisions in Colorado's Small Group Laws that Are Not in HIPAA, Colorado Division of Insurance.

Bill A

HOUSE SPONSORSHIP

Tochtrop, and Williams T.

SENATE SPONSORSHIP

Hagedorn, Fitz-Gerald, and Isgar

A BILL FOR AN ACT

CONCERNING THE CREATION OF A LOAN PROGRAM FOR NURSES.

Bill Summary

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

Task Force to Evaluate Health Care Needs. Makes legislative findings. Authorizes new student loans for qualified nursing programs. Limits the amount of moneys that may be loaned to a nursing student. Sets out repayment requirements.

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

SECTION 1. Article 38 of title 12, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PART to read:

PART 2

THE NURSING SHORTAGE ALLEVIATION ACT OF 2002

12-38-201. Legislative declaration. (1) THE GENERAL ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT COLORADO IS FACING A SHORTAGE OF NURSES. THE PROFESSION OF NURSING HAS UNDERGONE A CHANGE FROM A HEALING ART TO A CAREER PATH THAT ENTAILS LONG HOURS, ABUSIVE PATIENTS, MOUNTAINS OF PAPERWORK, AND STRENUOUS PHYSICAL DEMANDS, THUS DISCOURAGING THE RECRUITMENT OF NEW NURSES. SUCH SHORTAGE IMPACTS THE COLORADO COMMUNITY IN MANY WAYS; FOR EXAMPLE, NURSING DUTIES ARE SHIFTED TO PERSONS WHO ARE NOT ADEQUATELY TRAINED FOR NURSING DUTIES, NURSES ARE UNABLE TO PROVIDE SATISFACTORY INDIVIDUALIZED PATIENT CARE, AND THERE IS AN INSUFFICIENT NUMBER OF NURSES TO PROVIDE HOME HEALTH CARE. THEREFORE, THE GENERAL ASSEMBLY FINDS, DETERMINES, AND DECLARES IN THE INTERESTS OF THE RESIDENTS OF COLORADO THAT PERSONS INTERESTED IN NURSING AS A PROFESSION NEED ACCESS TO EDUCATION THROUGH DISTANCE LEARNING PROGRAMS AS WELL AS FINANCIAL AID.

12-38-202. Nursing student loans - cash fund. (1) AS USED IN THIS

SECTION:

(a) "APPROVED NURSING PROGRAM" MEANS A PROGRAM OFFERED BY A PUBLIC OR PRIVATE INSTITUTION IN THIS STATE THAT:

(I) CONSISTS OF COURSES OF INSTRUCTION IN REGULARLY SCHEDULED CLASSES LEADING TO A MASTER OF SCIENCE DEGREE, A BACHELOR OF SCIENCE DEGREE, AN ASSOCIATE DEGREE, OR A DIPLOMA IN NURSING, WHICH COURSES MAY BE OFFERED THROUGH ELECTRONIC METHODS OF COMMUNICATION; OR

(B) IS DESIGNED FOR PREPARATION FOR LICENSURE AS A LICENSED PRACTICAL NURSE AVAILABLE TO REGULARLY ENROLLED UNDERGRADUATE OR GRADUATE STUDENTS.

(b) "COMMISSION" MEANS THE COLORADO COMMISSION ON HIGHER EDUCATION.

(c) "NONTRADITIONAL STUDENT" MEANS A STUDENT WHO HAS NOT ATTENDED CLASSES AS A REGULAR FULL-TIME STUDENT FOR AT LEAST THREE YEARS.

(d) "PRACTICE OF PRACTICAL NURSING" SHALL HAVE THE SAME MEANING AS SET FORTH IN SECTION 12-38-103 (9).

(e) "PRACTICE OF PROFESSIONAL NURSING" SHALL HAVE THE SAME MEANING AS SET FORTH IN SECTION 12-38-103 (10).

(2) THE COMMISSION SHALL ADMINISTER A STUDENT LOAN PROGRAM PURSUANT TO THIS SECTION THAT SHALL MAKE LOANS DIRECTLY TO QUALIFIED STUDENTS ENROLLED IN APPROVED NURSING PROGRAMS IN THE STATE OF COLORADO AS PROVIDED FOR IN SUBSECTION (5) OF THIS SECTION. LOANS SHALL BE MADE TO AT LEAST ONE QUALIFIED STUDENT AT EACH INSTITUTION IN THE STATE THAT HAS AN APPROVED NURSING PROGRAM. THE MONEYS SHALL BE LOANED IN SUCH A MANNER AS CAN REASONABLE BE PREDICTED TO RESULT IN THE GREATEST INCREASE IN THE NUMBER OF PERSONS ENGAGED IN THE STUDY OF NURSING. LOANS SHALL BE MADE AVAILABLE FOR STUDENTS BEGINNING JANUARY 1, 2003, AND IN EACH ACADEMIC YEAR THEREAFTER. IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT A PORTION OF THE LOANS ALLOCATED BE USED TO ENHANCE THE EDUCATIONAL OPPORTUNITIES OF

NONTRADITIONAL STUDENTS AND ETHNIC MINORITY STUDENTS.

(3) (a) TO QUALIFY FOR A LOAN PURSUANT TO THIS SECTION, A STUDENT SHALL BE A RESIDENT OF COLORADO, INTEND TO PRACTICE IN COLORADO, BE MOTIVATED TO PRACTICE IN COLORADO, AND HAVE SUBSTANTIAL FINANCIAL NEED AS DETERMINED BY THE COMMISSION.

(b) EACH RECIPIENT OF A LOAN PURSUANT TO THIS SECTION SHALL AGREE TO ENGAGE IN THE PRACTICE OF NURSING IN THIS STATE FOR THE EQUIVALENT OF ONE YEAR OF FULL-TIME PRACTICE FOR EACH YEAR A LOAN IS RECEIVED.

(c) EACH APPROVED NURSING PROGRAM SHALL FORWARD TO THE COMMISSION THE NAMES OF THE QUALIFIED STUDENTS RECOMMENDED TO RECEIVE LOANS PURSUANT TO THIS SECTION, BASED ON THE CRITERIA SPECIFIED IN PARAGRAPHS (a) AND (b) OF THIS SUBSECTION (3), AND ANY OTHER INFORMATION AND DOCUMENTATION THE COMMISSION DEEMS NECESSARY.

(4) (a) LOANS RECEIVED PURSUANT TO THIS SECTION SHALL BE USED ONLY FOR EDUCATIONAL EXPENSES FOR AN APPROVED NURSING PROGRAM. THE USE OF LOAN MONEYS BY STUDENTS IS SUBJECT TO REVIEW BY THE COMMISSION.

(b) EACH LOAN SHALL BE FOR ONE ACADEMIC YEAR. EACH STUDENT SHALL BE LOANED NOT MORE THAN ONE THOUSAND DOLLARS PER ACADEMIC YEAR, AND NOT MORE THAN TWO THOUSAND DOLLARS TOTAL.

(c) IF A STUDENT WHO HAS RECEIVED A LOAN DISCONTINUES THE APPROVED NURSING PROGRAM BEFORE COMPLETING THE PROGRAM, THE STUDENT SHALL REPAY ONE HUNDRED PERCENT OF THE OUTSTANDING LOAN PRINCIPAL WITH SIMPLE INTEREST AT A RATE OF ONE POINT BELOW THE PRIME INTEREST RATE. SUCH REPAYMENT SHALL COMMENCE WITHIN SIX MONTHS AFTER THE DATE OF DISCONTINUATION OF THE COURSE OF STUDY AND SHALL BE COMPLETED WITHIN THE NUMBER OF YEARS FOR WHICH LOANS WERE AWARDED.

(d) AFTER COMPLETION OF THE APPROVED NURSING PROGRAM, A LOAN AWARDED TO A STUDENT SHALL BE FORGIVEN WHEN THE RECIPIENT OF

THE LOAN HAS ENGAGED IN THE FULL-TIME PRACTICE OF NURSING IN COLORADO FOR A PERIOD OF TIME WHICH WOULD BE THE EQUIVALENT OF FULL-TIME PRACTICE FOR THE NUMBER OF YEARS FOR WHICH LOANS WERE RECEIVED.

(e) IF A RECIPIENT OF A LOAN PURSUANT TO THIS SECTION IS NOT ENGAGED IN FULL-TIME PRACTICE, OR THE EQUIVALENT OF FULL-TIME PRACTICE, AS REQUIRED IN PARAGRAPH (b) OF SUBSECTION (3) OF THIS SECTION, THE RECIPIENT SHALL REPAY ONE HUNDRED TWENTY-FIVE PERCENT OF THE OUTSTANDING LOAN PRINCIPAL. SUCH REPAYMENT SHALL BE WITH SIMPLE INTEREST AT A RATE OF ONE POINT BELOW THE PRIME INTEREST RATE. INTEREST SHALL ACCRUE BEGINNING UPON THE COMPLETION OF THE APPROVED NURSING PROGRAM. REPAYMENT SHALL COMMENCE WITHIN SIX MONTHS AFTER THE DATE OF DISCONTINUATION OF THE PRACTICE OF NURSING IN COLORADO OR THE COMMENCEMENT OF LESS THAN FULL-TIME EMPLOYMENT AND SHALL BE COMPLETED WITHIN THE NUMBER OF YEARS FOR WHICH LOANS WERE AWARDED.

(5) THE COMMISSION, IN CONJUNCTION WITH INSTITUTIONS OFFERING APPROVED NURSING PROGRAMS, SHALL ADOPT AND PROMULGATE RULES NECESSARY FOR THE IMPLEMENTATION OF THIS SECTION. IN CONFORMANCE WITH SUCH RULES, INSTITUTIONS OFFERING APPROVED NURSING PROGRAMS MAY ACT AS AGENTS OF THE COMMISSION FOR THE DISTRIBUTION OF THE LOANS TO ELIGIBLE STUDENTS. THE COMMISSION MAY CONTRACT WITH OUTSIDE SOURCES TO IMPLEMENT THIS SECTION.

(6) THE COMMISSION MAY ACCEPT AND EXPEND GIFTS, GRANTS, AND DONATIONS FROM ANY SOURCE FOR THE IMPLEMENTATION AND AWARDING OF LOANS TO STUDENTS PURSUANT TO THIS SECTION.

(7) THE NURSING STUDENT LOAN CASH FUND, ALSO REFERRED TO IN THIS SUBSECTION (7) AS THE "FUND" IS HEREBY CREATED IN THE STATE TREASURY. THIS FUND SHALL BE THE REPOSITORY FOR LOAN REPAYMENTS RECEIVED PURSUANT TO SUBSECTION (4) OF THIS SECTION. ANY MONEYS IN THIS FUND MAY BE INVESTED BY THE STATE TREASURER PURSUANT TO SECTION 24-36-113, C.R.S. ALL MONEYS CREDITED TO THE FUND SHALL BE USED AS

PROVIDED IN THIS SECTION AND SHALL NOT BE DEPOSITED IN OR TRANSFERRED TO THE GENERAL FUND OF THIS STATE OR ANY OTHER FUND.

SECTION 2. Repeal. 23-3.3-701, Colorado Revised Statutes, is repealed as follows:

23-3.3-701. Colorado nursing scholarship program. ~~(1) The general assembly hereby authorizes the commission to establish a nursing scholarship program. Such program shall be administered in accordance with policies and procedures established by the commission. The general assembly may appropriate annually an amount for the support of such program.~~

~~(2) The commission shall determine, by guideline, the institutions of higher education eligible for participation in the scholarship program.~~

(3) ~~It is the intent of the general assembly that, under the policies and procedures established by the commission under subsection (1) of this section for awarding nursing scholarships, preference be given to individuals who shall work in federal qualifying health clinics and underserved areas with nursing shortages throughout the state.~~

~~(4) Repealed.~~

~~(5) Repealed.~~

SECTION 3. Effective date. This act shall take effect July 1, ____.

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

DRAFT

Bill A

Colorado Legislative Council Staff

STATE FISCAL IMPACT

Drafting Number:	LLS 02-0106	**Date:**	December 4, 2001
Prime Sponsor(s):	Rep. Tochtrop	**Bill Status:**	Health Care Needs Task Force
	Sen. Hagedorn	**Fiscal Analyst:**	Geoff Barsch (303-866-4102)

TITLE: CONCERNING THE CREATION OF A LOAN PROGRAM FOR NURSES.

Fiscal Impact Summary	FY 2002/2003	FY 2003/2004
State Revenues		
Nursing Student Loan Cash Fund	$0	$15,377
State Expenditures		
General Fund - Colorado Nursing Scholarship Program	($335,856)	$0
General Fund - Nursing Student Loan Program	335,856	335,856
FTE Position Change	0.0 FTE	0.0 FTE
Other State Impact: TABOR refund from General Fund*		
Effective Date: Upon signature of the Governor		
Appropriation Summary for FY 2001/2002: Department of Higher Educaiton ($335,856) GF - Nursing Scholarship Program $335,856 GF - Nursing Student Loan Program		
Local Government Impact: None		

* *Under current law, the state is required to refund 105 percent of the amount estimated to be refunded by the six-tier sales tax refund mechanism. TABOR refunds will be affected beginning in FY 2004-05.*

Summary of Legislation

This bill requires the Colorado Commission on Higher Educaiton (CCHE) to issue new student loans for students enrolled in qualified nursing programs and repeals the existing Colorado Nursing Scholarship Program. The bill limits the amount of the nursing loans and specifies repayment requirements. Students may repay their loan by practicing nursing in Colorado for one year for each year a loan is received. If the student does not practice nursing in the state, the bill specifies the terms of cash repayment. All repayment proceeds are to be deposited in the Nursing Student Loan Cash Fund. The CCHE is authorized to use loan proceeds to make new loans.

Background

The bill states the General Assembly's intent to establish a nursing loan program to encourage students to practice nursing in Colorado, while repealing the current nursing scholarship program. The current nursing program is administered according to policies and procedures established by the CCHE. Key similarities and differences between the current and the proposed program are shown below.

Feature	Current Program	Proposed Program
Eligibility Criteria	Must be a Colorado resident; students committed to nursing in shortage areas with documented financial need are funded first.	Must be a Colorado resident committed to nursing in Colorado and have a documented financial need.
Maximum Award	Actual tuition and fees.	$1,000 per year; $2,000 total.
Service Repayment	Allows for service repayment for students who practice nursing in designated shortage areas in Colorado.	Allows for service repayment for students who practice nursing anywhere in Colorado.
Cash Repayment	Students who do not practice nursing are required to pay back program funds with interest over five years.	Students who do not practice nursing are required to pay back program funds with interest over one or two years. Students who complete their academic program are required to pay back 125% of program funds.
Repaid loan funds	Revert to the General Fund	Stay in the Nursing Student Loan Cash Fund for future loans.

Funding for the current program has been relatively stable, including appropriation amounts of $220,800 from FY 1992-93 through FY 1997-98, $238,800 from FY 1998-99 through FY 2000-01, and $335,856 in FY 2001-02 (the 2001 Long Bill included a footnote directing the $97,056 increase in funding in the nursing scholarship program to go to nursing students attending rural programs). This fiscal note assumes the same level of funding for FY 2002-03.

State Revenues

Beginning in FY 2003-04, loan recipients who do not complete their nursing program will be required to repay 100 percent of their loan amount. Beginning in FY 2004-05, recipients who complete their program but do not practice nursing in Colorado, will be required to repay 125 percent of their loan amount. Terms of repayment include the calculation of interest beginning upon the completion of the academic program and a repayment period equal to the period for which the loan

was made. It is estimated that 90 percent of students will complete their program, and that 75 percent of students will practice in Colorado.

This fiscal note assumes that $335,000 will be lent in FY 2002-03. The total amount of loan principal to be repaid in FY 2003-04 is estimated to be $33,500 (10% x $335,000). State Central Collections reports a historical collection rate of approximately 45 percent on higher education debts.

Therefore, it is estimated that $15,377 (45% of $33,500 plus interest) will be collected in FY 2003-04. Table 2 shows the estimated revenue collected through FY 2005-06. Moneys collected will be deposited into the newly-created Nursing Student Loan Cash Fund for making future nursing student loans.

Table 2. Estimated Nursing Student Loan Revenue

	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06
Amount available for loans[1]	$335,000	$350,377	$372,705	$392,841
Cash repayment - Students leaving their program (100% of principal)	0	33,500	35,038	37,271
Cash repayment - Students not practicing (125% of principal)	0	0	75,375	66,616
Total amount due (inlcuding interest)	0	34,170	83,790	128,535
Total amound collected	0	15,377	37,705	57,841

[1] Assumes continuing General Fund appropriation of $335,000.

State Expenditures

This bill creates a Nursing Student Loan Program and repeals the existing Colorado Nursing Scholarship Program. This fiscal note assumes that the General Fund appropriation for the current program will be redirected to the new program. The current Colorado Nursing Scholarship Program appropriation is $335,856.

The bill limits the loan amount for individual students to $1,000 per student per year, and $2,000 in total. The current program is limited to tuition and fee charges, which are generally higher than $1,000. For FY 2000-01, 147 students were awarded an average of $1,600. Although the proposed program will make awards to an estimated 335 students, any additional workload can be absorbed within the current CCHE resources.

State Appropriations

This fiscal note indicates that the Department of Higher Education will require a General Fund appropriation of $335,856 to the Nursing Student Loan Program, and a General Fund appropriation reduction to the Colorado Nursing Scholarship Program of the same amount for FY 2002-03.

Departments Contacted

Higher Education Treasury

Omissions and Technical or Mechanical Defects

The bill includes an effective date of July 1, but does not specifiy which year. This fiscal note assumes the bill will take effect upon signature of the Governor, and will be implemented July 1, 2002.

Bill B

HOUSE SPONSORSHIP
Tochtrop, Clapp, Miller, Spradley, and Williams T.

SENATE SPONSORSHIP
Fitz-Gerald, Hagedorn, Isgar, and Owen

A BILL FOR AN ACT

CONCERNING THE CREATION OF AN ADVISORY COMMITTEE TO STUDY THE ADMINISTRATION OF MEDICATIONS BY CERTIFIED NURSE AIDES.

Bill Summary

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

Task Force to Evaluate Health Care Needs. Creates an advisory committee to study the administration of medications by certified nurse aides in long-term care facilities and by home health care providers. Requires the committee to study:

- The benefits and risks associated with using medication aides, including the effect on patient care;
- The level of experience required in order to qualify to train as a medication aide;
- The extent of classroom training and education required to be a medication aide; and
- The scope of practice of a medication aide.

Requires the advisory committee to make recommendations and report such recommendations to the senate health, environment, children and families committee and the house health, environment, welfare, and institutions committee.

Repeals the advisory committee on December 31, 2002.

Defines terms.

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

SECTION 1. 12-38.1-102, Colorado Revised Statutes, is amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS to read:

12-38.1-102. Definitions. As used in this article, unless the context otherwise requires:

(3.3) "DIVISION" MEANS THE HEALTH FACILITIES REGULATION DIVISION IN THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT.

(3.5) "LONG-TERM CARE FACILITY" SHALL HAVE THE SAME MEANING AS SET FORTH IN SECTION 26-11.5-103 (3), C.R.S.

SECTION 2. Article 38.1 of title 12, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

12-38.1-108.5. Medication administration advisory committee - created - repeal. (1) WITHIN FOURTEEN DAYS AFTER THE ENACTMENT OF THIS SECTION, THE BOARD, IN CONJUNCTION WITH THE DIVISION, SHALL APPOINT AN ADVISORY COMMITTEE TO STUDY THE ADMINISTRATION OF MEDICATIONS BY CERTIFIED NURSE AIDES IN LONG-TERM CARE FACILITIES.

(2) THE ADVISORY COMMITTEE SHALL HAVE TEN MEMBERS WHICH SHALL INCLUDE THE FOLLOWING PERSONS:

(a) ONE MEMBER OF THE BOARD;

(b) ONE REPRESENTATIVE FROM THE DIVISION;

(c) TWO PRACTICAL OR PROFESSIONAL NURSES LICENSED PURSUANT TO ARTICLE 38 OF THIS TITLE;

(d) ONE PHYSICIAN LICENSED PURSUANT TO ARTICLE 36 OF THIS TITLE;

(e) ONE PHARMACIST LICENSED PURSUANT TO ARTICLE 22 OF THIS TITLE;

(f) TWO LONG-TERM CARE ADVOCATES WHO REPRESENT THE RESIDENTS OR PATIENTS IN LONG-TERM CARE FACILITIES;

(g) ONE INDIVIDUAL WHOM THE BOARD AND THE DIVISION HAVE DETERMINED TO BE QUALIFIED TO EVALUATE THE EXPANSION OF THE DUTIES OF CERTIFIED NURSE AIDES TO INCLUDE THE ADMINISTRATION OF MEDICATIONS IN LONG-TERM CARE FACILITIES; AND

(h) ONE HOME HEALTH CARE PROVIDER.

(3) THE ADVISORY COMMITTEE SHALL STUDY THE ISSUE OF ALLOWING CERTIFIED NURSE AIDES TO ADMINISTER MEDICATIONS IN LONG-TERM CARE FACILITIES. THE STUDY SHALL INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING:

(a) THE BENEFITS AND RISKS ASSOCIATED WITH TRAINING CERTIFIED NURSE AIDES TO BECOME MEDICATION AIDES;

(b) THE EFFECT OF THE USE OF MEDICATION AIDES ON THE LEVEL OF PATIENT CARE;

(c) THE LEVEL OF EXPERIENCE A CERTIFIED NURSE AIDE MUST HAVE IN ORDER TO BE CONSIDERED FOR TRAINING AS A MEDICATION AIDE;

(d) THE EXTENT AND CONTENT OF CLASSROOM TRAINING AND EDUCATION REQUIRED TO BE A MEDICATION AIDE; AND

(e) THE EXTENT AND LIMIT TO THE SCOPE OF PRACTICE OF A CERTIFIED NURSE AIDE WHO HAS COMPLETED TRAINING AS A MEDICATION AIDE.

(4) THE ADVISORY COMMITTEE SHALL DEVELOP RECOMMENDATIONS RESULTING FROM ITS STUDY ON THE TRAINING OF CERTIFIED NURSE AIDES TO BE MEDICATION AIDES, AND THE USE OF MEDICATION AIDES IN LONG-TERM CARE FACILITIES.

(5) THE ADVISORY COMMITTEE SHALL REPORT ITS FINDINGS AND RECOMMENDATIONS TO THE SENATE HEALTH, ENVIRONMENT, CHILDREN AND FAMILIES COMMITTEE AND THE HOUSE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEE NO LATER THAN APRIL 15, 2002.

(6) (a) THIS SECTION IS REPEALED, EFFECTIVE DECEMBER 31, 2002.

(b) PRIOR TO SAID REPEAL, THE ADVISORY COMMITTEE TO STUDY THE ADMINISTRATION OF MEDICATIONS BY CERTIFIED NURSE AIDS SHALL BE REVIEWED AS PROVIDED FOR IN SECTION 2-3-1203, C.R.S.

SECTION 3. 2-3-1203 (3), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

2-3-1203. Sunset review of advisory committees. (3) The following dates are the dates for which the statutory authorization for the designated advisory committees is scheduled for repeal:

(o) DECEMBER 31, 2002: THE ADVISORY COMMITTEE TO STUDY THE ADMINISTRATION OF MEDICATIONS BY CERTIFIED NURSE AIDES ESTABLISHED IN SECTION 12-38.1-108.5, C.R.S.

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

DRAFT

Colorado Legislative Council Staff

STATE FISCAL IMPACT

No State General Fund Impact

Drafting Number: LLS 02-0107
Prime Sponsor(s): Rep. Tochtrop
Sen. Fitz-Gerald

Date: November 9, 2001
Bill Status: Health Care Needs Task Force
Fiscal Analyst: Melodie Jones (303) 866-4976

TITLE: CONCERNING THE CREATION OF AN ADVISORY COMMITTEE TO STUDY THE ADMINISTRATION OF MEDICATIONS BY CERTIFIED NURSE AIDES IN LONG-TERM CARE FACILITIES.

Fiscal Impact Summary	FY 2002/2003	FY 2003/2004
State Revenues Cash Fund	$0	$0
State Expenditures Cash Fund	$10,345	$0
FTE Position Change	0.0	0.0
Other State Impact: None		
Effective Date: Upon the signature of the Governor.		
Appropriation Summary for FY 2002/2003: Department of Regulatory Agencies -- $10,345 CF (Note: The appropriation required is for the current fiscal year.)		
Local Government Impact: None		

Summary of Legislation

This bill requires the State Board of Nursing in the Department of Regulatory Agencies, together with the Health Facilities Regulation Division in the Department of Public Health and Environment, to appoint a ten-member advisory committee to study the administration of medications by certified nurse aides in long-term care facilities. The study shall include:

- the benefits and risks associated with training certified nurse aides to become medication aides;
- the effect of the use of medication aides on the level of patient care;
- the level of experience a certified nurse aide must have in order to be considered for training as a medication aide;
- the extent and content of classroom training and education required to be a medication aide; and

- the extent and limit to the scope of practice of a certified aide who has completed training as a medication aide.

The advisory committee shall report its findings and recommendations to the General Assembly no later than ***April 15, 2002.*** The advisory committee is repealed on December 31, 2002.

State Expenditures

The advisory committee will require $10,345 cash funds for the Division of Registrations, Department of Regulatory Agencies in FY 2001-02 only. No costs will be incurred in subsequent years. The estimated fiscal impact is based on the following assumptions:

- The advisory committee will meet a total of 12 times to conduct the study and finalize their report. This analysis assumes the meetings must occur before April 15, 20002, based on the time frames established in the bill.
- The advisory committee members are eligible for expense reimbursement.
- The Nursing Board will contract for staff support for the advisory committee.
- The advisory committee will require operating funding for photocopying, telephone calls, supplies and legal services.

Table 1. Costs for Advisory Committee to Study the Administration of Medications by Certified Nurse Aides in Long-Term Care Facilities

Cost Components	FY 2001-02
Travel expenses for advisory committee members (12,480 miles * 0.28 mile reimbursement rate)	$5,294
Contract Personal Services (Administrative Assistant III @ $14.02/hour * 276 hours)	$3,870
PERA and Medicare	$439
Operating Expenses (telephone calls, printing, photocopying, supplies)	$275
Legal Services (8 hours to review committee's final report and recommendations)	$467
Total Costs	$10,345

State Appropriation

The Department of Regulatory Agencies, Division of Registrations will require a cash fund appropriation of $10,345 for FY 2001-02, the current fiscal year. The fund balance for the Nurse Aide's account in the Division of Registrations' cash fund is sufficient to meet the appropriation requirement without an increase in registration fees.

Departments Contacted

Regulatory Agencies Public Health and Environment

Bill C

HOUSE SPONSORSHIP

Williams T.

SENATE SPONSORSHIP

Owen

A BILL FOR AN ACT

CONCERNING THE CREDIT AGAINST THE COLORADO INCOME TAX FOR HEALTH CARE PROFESSIONALS PRACTICING IN RURAL HEALTHCARE PROFESSIONAL SHORTAGE AREAS.

Bill Summary

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

Task Force to Evaluate Health Care Needs. Makes the existing credit against the state income tax for health care professionals practicing in rural health care professional shortage areas, currently allowed for certain income tax years in which the state controller certifies a specified amount of excess state revenues for the state fiscal year ending in that income tax year, a permanent tax credit that shall be allowed for any income tax year commencing on or after January 1, 2002, but prior to January 1, 2011.

For income tax years commencing on or after January 1, 2003, adds registered nurses, licensed practical nurses, and pharmacists to the list of health care professionals that may claim the credit.

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

SECTION 1. 39-22-126 (1) (b), (2) (a), (3), (9), and (10) (a), Colorado Revised Statutes, are amended, and the said 39-22-126 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

39-22-126. Credit for health care professionals practicing in rural health care professional shortage areas - legislative declaration - definitions.

(1) (b) The general assembly further finds and declares that creating an income tax credit for health care professionals practicing in health care professional shortage areas IN ACCORDANCE WITH SUBSECTION (3) OF THIS SECTION is a reasonable method of refunding a portion of the excess state revenues required to be refunded in accordance with section 20 (7) (d) of article X of the state constitution.

(2) As used in this section, unless the context otherwise requires:

(a) (I) For the income tax year commencing on or after January 1, 2000, but prior to January 1, 2001, "health care professional" means a physician, physician assistant, or advanced practice nurse who is licensed as such under the laws of this state.

(II) For any income tax year commencing on or after January 1, 2001, but prior to January 1, 2002, "health care professional" means a physician, physician assistant, advanced practice nurse, or dentist who is licensed as such under the laws of this state.

(III) For any income tax year commencing on or after January 1, 2002,

BUT PRIOR TO JANUARY 1, 2003, "health care professional" means a physician, physician assistant, advanced practice nurse, dentist, or dental hygienist who is licensed as such under the laws of this state.

(IV) FOR ANY INCOME TAX YEAR COMMENCING ON OR AFTER JANUARY 1, 2003, "HEALTH CARE PROFESSIONAL" MEANS A PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCED PRACTICE NURSE, DENTIST, DENTAL HYGIENIST, REGISTERED NURSE, LICENSED PRACTICAL NURSE, OR PHARMACIST WHO IS LICENSED AS SUCH UNDER THE LAWS OF THIS STATE.

(3) Subject to subsection (9) of this section, for any income tax year commencing on or after January 1, 2000, but prior to ~~January 1, 2008~~ JANUARY 1, 2002, if, based on the financial report prepared by the controller in accordance with section 24-77-106.5, C.R.S., the controller certifies that the amount of excess state revenues for the state fiscal year ending in that income tax year exceeds the limitation on state fiscal year spending imposed by section 20 (7) (a) of article X of the state constitution and the voters statewide either have not authorized the state to retain and spend all of the excess state revenues or have authorized the state to retain and spend only a portion of the excess state revenues for that fiscal year, there shall be allowed to each taxpayer a credit against the tax imposed by this article in an amount equal to one-third of the amount of the student loan referenced in paragraph (d) of subsection (4) of this section up to the amount of the taxpayer's actual income tax liability for the taxable year for which the credit is claimed; except that, in no event shall the aggregate amount of the credit claimed by the taxpayer for all income tax years pursuant to this section exceed the amount of the student loan referenced in paragraph (d) of subsection (4) of this section.

(3.5) FOR ANY INCOME TAX YEAR COMMENCING ON OR AFTER JANUARY 1, 2002, BUT PRIOR TO JANUARY 1, 2011, THERE SHALL BE ALLOWED TO EACH TAXPAYER A CREDIT AGAINST THE TAX IMPOSED BY THIS ARTICLE IN AN AMOUNT EQUAL TO ONE-THIRD OF THE AMOUNT OF THE STUDENT LOAN REFERENCED IN PARAGRAPH (d) OF SUBSECTION (4) OF THIS SECTION UP TO THE AMOUNT OF THE TAXPAYER'S ACTUAL INCOME TAX LIABILITY FOR THE TAXABLE YEAR FOR WHICH THE CREDIT IS CLAIMED; EXCEPT THAT, IN NO EVENT SHALL THE AGGREGATE AMOUNT OF THE CREDIT CLAIMED BY THE TAXPAYER FOR ALL INCOME TAX YEARS PURSUANT TO THIS SECTION EXCEED THE AMOUNT OF THE STUDENT LOAN REFERENCED IN PARAGRAPH (d) OF SUBSECTION (4) OF THIS SECTION.

(9) If, based on the financial report prepared by the controller in accordance with section 24-77-106.5, C.R.S., the controller certifies that the

amount of state revenues for any state fiscal year commencing on or after July 1, 1999, but prior to ~~July 1, 2008~~ JULY 1, 2001, exceeds the limitation on state fiscal year spending imposed by section 20 (7) (a) of article X of the state constitution for that fiscal year by less than two hundred eighty-five million dollars, as adjusted pursuant to subsection (10) of this section, then the state income tax credit authorized by subsection (3) of this section shall not be allowed for the income tax year in which said state fiscal year ended.

(10) (a) No later than ~~October 1 of any given calendar year commencing on or after January 1, 2001~~ OCTOBER 1, 2001, the executive director shall ~~annually~~ adjust the dollar amount specified in subsection (9) of this section to reflect the rate of growth of Colorado personal income for the calendar year immediately preceding the calendar year in which such adjustment is made. For purposes of this paragraph (a), "the rate of growth of Colorado personal income" means the percentage change between the most recent published annual estimate of total personal income for Colorado, as defined and officially reported by the bureau of economic analysis in the United States department of commerce for the calendar year immediately preceding the calendar year in which the adjustment is made and the most recent published annual estimate of total personal income for Colorado, as defined and officially reported by the bureau of economic analysis in the United States department of commerce for the calendar year prior to the calendar year immediately preceding the calendar year in which the adjustment is made.

SECTION 2. Effective date. This act shall take effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly that is allowed for submitting a referendum petition pursuant to article V, section 1 (3) of the state constitution; except that, if a referendum petition is filed against this act or an item, section, or part of this act within such period, then the act, item, section, or part, if approved by the people, shall take effect on the date of the official declaration of the vote thereon by proclamation of the governor.

DRAFT

Bill C

Colorado Legislative Council Staff

STATE FISCAL IMPACT

Drafting Number:	LLS 02-0108	**Date:**	November 28, 2001
Prime Sponsor(s):	Rep. Williams T. Sen. Owen	**Bill Status:** **Fiscal Analyst:**	Health Care Needs Task Force Harry Zeid (303-866-4753)

TITLE: CONCERNING THE CREDIT AGAINST THE COLORADO INCOME TAX FOR HEALTH CARE PROFESSIONALS PRACTICING IN RURAL HEALTHCARE PROFESSIONAL SHORTAGE AREAS.

Fiscal Impact Summary	FY 2002/2003	FY 2003/2004	FY 2004/2005
State Revenues General Fund	($200,000)	($575,000)	($750,000)
State Expenditures General Fund			
FTE Position Change	0.0 FTE	0.0 FTE	0.0 FTE
Rural Healthcare Refund Mechanism* **Six-Tier Sales Tax Refund Mechanism**		0 ($210,000)	0 ($603,750)

Effective Date: 90 days after adjournment (August 6, 2002) unless a referendum petition is filed; and applies to state income tax years commencing on or after **January 1, 2002**.

Appropriation Summary for FY 2002/2003: None Required

Local Government Impact: None

****Based on the current Legislative Council staff revenue forecast, the $285 million trigger for the health care professional TABOR refund mechanism will not occur again until FY 2006-07.***

Note: The official Legislative Council staff revenue forecast for September 2001, as adjusted for the special session, indicates a TABOR revenue surplus for the next several years. However, revenue tracking since the most recent forecast indicates a potential for a revision downward of the surplus amount. If this occurs, the fiscal note will be revised to reflect the most recent revenue forecast.

Summary of Legislation

Under current law, Colorado provides a state income tax credit to certain health care professionals that work in a rural health care professional shortage area and have an outstanding student loan. The credit is only available for years in which the state has excess TABOR revenue of at least $285 million, adjusted for personal income growth. This bill repeals the refund mechanism and replaces it with a permanent tax credit beginning with income tax years commencing on or after January 1, 2002, but prior to January 1, 2011. Additionally, the bill adds registered nurses, licensed

practical nurses, and pharmacists to the list of health care professionals that may qualify for the tax credit beginning with the 2003 income tax year.

State Revenues

Background. Under current law, Colorado provides a state income tax credit to certain health care professionals as a refund of surplus revenues. The credit applies to a physician, physician assistant, advanced practice nurse, dentist, or dental hygienist who is licensed in Colorado and practices in a rural health care professional shortage area. In order to claim the credit, the health care professional must be a borrower on a student loan issued under a recognized student loan program that is made and used to finance higher education opportunities resulting in a degree that is required to enable the individual to be licensed or certified as a health care professional. The credit is equal to one-third of the amount of the student loan or one-third of the balance due and owing on the student loan, as of the date of the first payment on the loan, or January 1, 2000, whichever is later, up to the amount of the taxpayer's actual state income tax liability for the taxable year for which the credit is claimed.

Making the TABOR Refund Mechanism Permanent. Converting Colorado's current income tax credit for rural health care professionals from a TABOR refund mechanism to a permanent income tax credit will have no effect on taxpayers who claim the tax credit, other than guaranteeing them the tax credit in every year rather than only in years in which there are sufficient surplus TABOR revenues. However, the change will affect the state's accounting of General Fund revenues, the General Fund Reserve, and the amount of money available for refund through the six-tier sales tax refund mechanism. This will occur because a permanent income tax credit is identified as a General Fund revenue reduction on an accrual accounting basis and a TABOR refund mechanism is fully booked in the state fiscal year in which the refund is provided and is not considered a revenue reduction.

The current Legislative Council staff revenue forecast projects that making the current health care professional tax credit permanent will reduce state General Fund revenue by $400,000 annually beginning in FY 2002-03 ($200,000 for the six-month period of FY 2001-02 beginning January 1, 2002 on an accrual accounting basis). Because there will be a reduction in state General Fund revenue, money available for the six-tier sales tax refund mechanism will be decreased by 105 percent of those amounts in the following year, as per the provisions of HB99-1001. The net impact on the six-tier refund mechanism of this provision of the bill is a decrease of $210,000 in FY 2002-03, and $420,000 in FY 2003-04, respectively.

Based on the current Legislative Council staff revenue forecast, the TABOR trigger for the health care professional tax credit will not occur again until FY 2006-07. Therefore, it is projected that this tax credit will not be available to health care professionals until the 2006 income tax year. The six-tier sales tax refund mechanism is currently projected to be available to taxpayers during this time period.

Adding nurses and pharmacists. The bill adds registered nurses, licensed practical nurses, and pharmacists to the list of rural health care professionals that may claim the credit, effective for income tax years commencing on or after January 1, 2003.

Based on estimates contained in the fiscal note for HB00-1063 and HB01-1257, it was assumed that 40 doctors would qualify for the credit in 2001, 50 in 2002, and 60 in 2003 and beyond. Based on the United States Bureau of Labor Statistics (BLS) data, there were 577,000 physicians in 1998, 185,000 pharmacists, 2.1 million registered nurses, and 692,000 licensed practical nurses. The proportion of pharmacists to doctors is .32 to 1. The proportion of registered nurses to doctors is 3.64 to 1. The proportion of licensed practical nurses to doctors is 1.2 to 1. Based on these proportions of health occupations to doctors in the United States, it is assumed that in income tax year 2003 there will be 19 qualifying pharmacists, 218 qualifying registered nurses, and 72 qualifying licensed practical nurses for the tax credit in rural health care shortage areas. No growth in the number of qualified health care professionals is assumed beyond 2003.

The median income of all physicians in 1997, according to the American Medical Association was $164,000. In 1998, median incomes were $66,220 for pharmacists, $40,690 for registered nurses, and $26,940 for licensed practical nurses. After adjusting median income for physicians based on the Bureau of Labor Statistics consumer price index for Physicians' Services, for each dollar of physician median income, the median income is 39 cents for pharmacists; 24 cents for registered nurses; and 16 cents for licensed practical nurses.

In the fiscal note for HB00-1063, it was assumed that the average state liability of doctors was $5,000. For purposes of this fiscal note, it is assumed that the average state liability of pharmacists is $1,960 (.392 x $5,000 = $1,960); of registered nurses, $1,205 (.241 x $5,000 = $1,205); and of licensed practical nurses, $800 (.160 x $5,000 = $800). On this basis, the annual state General Fund revenue reduction impact of adding registered nurses, licensed practical nurses, and pharmacists to the current credit is approximately $350,000 per year ($175,000 in FY 2002-03 in an accrual accounting basis). There will also be a reduction to the six-tier sales tax refund mechanism of $183,750 in FY 2003-04.

Summary. Table 1 summarizes the impact of making the health care professional TABOR refund mechanism permanent, eliminating it as a TABOR refund mechanism, and expanding the tax credit to include nurses and pharmacists.

Table 1. Impact of Bill C

	FY 2001-02	FY 2002-03	FY 2003-04
Making the Tax Credit Permanent			
General Fund Revenue	($200,000)	($400,000)	($400,000)
Six-Tier Sales Tax Refund Mechanism		($210,000)	($420,000)
Eliminate the TABOR Refund Mechanism*			
TABOR Refund Mechanism		0	0
Six-Tier Sales Tax Refund Mechanism		0	0
Impact of Adding Nurses and Pharmacists			
General Fund Revenue		($175,000)	($350,000)
Six-Tier Sales Tax Refund Mechanism			($183,750)
Combined Impact of Bill C			
General Fund Revenue	($200,000)	($575,000)	($750,000)
Combined Impact on TABOR Refunds		($210,000)	($603,750)

**There is no impact because the threshold for implementing the existing TABOR refund mechanism ($285 million in surplus state TABOR revenue) will not be met. If revenues were such that the existing mechanism would be used, then an impact would occur.*

State Expenditures

State expenditures will be unaffected by the bill. As a TABOR refund mechanism, the value of the present income tax credit for rural health care professionals is currently recorded and tracked separately by the Department of Revenue. The value of the tax credit that exceeds the taxpayer's state income tax liability, when combined with other tax credits, is refunded to the taxpayer. Although the tax credit will be permanent, the tax credit continues to be refundable under these circumstances.

Other State Impacts

Table 2 summarizes the net impact of this bill on state obligations. The changes in Table 2 are changes from a base that includes continuing capital construction projects. General Fund appropriations will be reduced by this bill and less money will be available in the excess General Fund reserve.

Table 2. Additional Impact of Bill C (millions of dollars)

	FY 2001/02	FY 2002/03	FY 2003/04
General Fund Revenue*	($0.200)	($0.575)	($0.740)
SB 97-1 Diversion			
Excess General Fund Reserve	($0.200)	($0.575)	($0.740)
Federal Income Taxes Paid by Colorado Taxpayers	$0.032	$0.093	$0.120
TABOR Refund (from prior year's excess revenues)		($0.210)	($0.604)

**General Fund revenue figures in this overview table may differ from those shown in the Fiscal Impact Summary table due to possible over-refunding of excess TABOR revenue in the prior fiscal year.*

State Appropriations

The fiscal note implies that no additional state spending authority or appropriation is required for FY 2002-03 to implement the provisions of the bill.

Departments Contacted

Revenue Legislative Council Staff

Bill D

HOUSE SPONSORSHIP

Spradley, and Williams T.

SENATE SPONSORSHIP

McElhany, and Owen

A BILL FOR AN ACT

CONCERNING THE GUARANTEED ISSUE OF HEALTH INSURANCE BENEFITS FOR BUSINESS GROUPS OF ONE.

Bill Summary

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

Task Force to Evaluate Health Care Needs. Eliminates the requirement that a business group of one work 24 hours per week in order to qualify as a business group of one.

Clarifies that a carrier offering health benefit coverage to a small employer need only offer coverage to a business group of one during the open enrollment periods for a business group of one.

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

SECTION 1. 10-16-102 (6) (a) and (6) (b), Colorado Revised Statutes, are amended to read:

10-16-102. Definitions. As used in this article, unless the context otherwise requires:

(6) (a) "Business group of one" means, for purposes of qualification, an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership ~~who works twenty-four hours or more a week on a permanent basis and~~ who has carried on significant business activity for a period of at least one year prior to application for coverage AND has GENERATED FROM SUCH BUSINESS ACTIVITY gross income, as indicated on federal internal revenue service forms 1040, schedule C, F, or SE, or other forms recognized by the federal internal revenue service for income reporting purposes, ~~which generated gross income~~ from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual's income for one year out of the most recent consecutive three-year period. For the purposes of this subsection (6), "substantial part of such individual's income" means income derived from business activities of the business group of one that are sufficient to pay for annual health insurance premiums for the business group of one.

(b) "Business group of one" includes a full-time household employee who ~~works twenty-four hours or more a week on a permanent basis as a household employee, if that employee~~ has derived at least a substantial part of

such employee's earned income for one year out of the preceding three-year period from household employment, and if the employee's employer, on at least fifty percent of the days in a normal work week during the preceding calendar quarter, employed at least one household employee.

"**SECTION 2.** 10-16-105 (7.3) (i), Colorado Revised Statutes, is amended to read:

10-16-105. Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans. (7.3) (i) In lieu of accepting applications from and guarantee issuing the basic and standard plans to business groups of one year round, small employer carriers may limit their issuance of coverage ~~as provided in this paragraph (i). A small employer carrier may establish open enrollment periods for guarantee issued basic or standard plan applications from business groups of one for a period of thirty-one days following the birth date of the person qualifying as a business group of one. A small employer carrier may establish annual open enrollment periods for business groups of one for thirty-one days following the birth date of the applicant and may limit issuance of a basic health benefit plan and a standard health benefit plan to such thirty-one day period. Carrier marketing and sales materials for business groups of one shall clearly disclose the open enrollment period. If a person qualifying as a business group of one applies for coverage under a plan other than the basic or standard plan, and if the business group of one is denied coverage as provided by law, then the small employer carrier shall offer the business group of one a choice of coverage under the basic or standard plan during the applicant's appropriate open enrollment period. A small employer carrier shall accept applications from business groups of one for a basic or standard plan through the thirty-first day after the birth date of the person qualifying as a business group of one. The date upon receipt of the signed application and the applicant's birth date shall be used in determining whether the thirty-one day open enrollment applies to a particular person qualifying as a business group of one. Eligible dependents of such person may also be covered at the same time as the applicant. Small employer carriers that use open enrollment periods shall also accept applications from business groups of one and issue a basic or standard plan as provided by law if such applications are submitted within thirty-one days of any one of the following events:~~ BY OFFERING A BASIC AND STANDARD PLAN TO BUSINESS GROUPS OF ONE THAT REDUCES THE AMOUNT OF COVERED BENEFITS UP TO FIFTY PERCENT FOR THE FIRST TWELVE MONTHS OF COVERAGE FOR PREEXISTING CONDITIONS FROM THE DATE OF APPLICATION FOR COVERAGE AS

A BUSINESS GROUP OF ONE.

~~(I) A person qualifying as a business group of one exhausts state or federal continuation coverage;~~

~~(II) The date a person initially meets the requirements of section 10-16-102 (6) and whose birth date is more than thirty-one days after so doing; or~~

~~(III) A person qualifying as a business group of one involuntarily loses other creditable coverage. This subparagraph (III) shall not apply in cases of failure to pay premium, fraud, or a voluntary decision on the part of such person to terminate other creditable coverage.~~

SECTION 3. 10-16-116 (1) (e), Colorado Revised Statutes, is amended to read:

10-16-116. Catastrophic health insurance - coverage. (e) For group coverage, cover an employee and eligible dependents regardless of health status; ~~except that a business group of one may be restricted to obtaining coverage during an open enrollment period as specified by section 10-16-105 (7.3) (i);~~".

SECTION 4. Effective date - applicability. (1) This act shall take effect January 1, 2003, unless a referendum petition is filed during the ninety-day period after final adjournment of the general assembly that is allowed for submitting a referendum petition pursuant to article V, section 1 (3) of the state constitution. If such a referendum petition is filed against this act or an item, section, or part of this act within such period, then the act, item, section, or part shall take effect on the specified date only if approved by the people.

(2) The provisions of this act shall apply to health benefit plans issued or renewed on or after the applicable effective date of this act.

DRAFT

Colorado Legislative Council Staff

NO FISCAL IMPACT

Drafting Number:	LLS 02-0109	**Date:**	November 9, 2001
Prime Sponsor(s):	Rep. Spradley	**Bill Status:**	Health Care Needs Task Force
	Sen. McElhany	**Fiscal Analyst:**	Melodie Jones (303-866-4976)

TITLE: CONCERNING THE GUARANTEED ISSUE OF HEALTH INSURANCE BENEFITS FOR BUSINESS GROUPS OF ONE.

Summary of Assessment

This bill eliminates the requirement that a business group of one work 24 hours per week in order to qualify as such. The bill allows a small employer carrier to offer a basic and standard plan to a business group of one that reduces the amount of benefits covered by 50 percent during the first 12 months of coverage. The bill also eliminates provisions in statute restricting open enrollment periods for business groups of one to the 31-day period after the birth date of the person qualifying as a business group of one.

The bill is assessed as having no fiscal impact. The Division of Insurance, Department of Regulatory Agencies, estimates 50 hours of staff time will be needed to modify the regulations for small group carriers (General Professional V @ $24.90/hour * 50 hours = $1,245). In addition, the Division estimates that small group filings will become more complex requiring additional staff time (Rate/Financial Analyst II @ $19.66/hour * 6.5 hours + Actuary III @ $28.13/hour * 39 hours = $1,225). However, these costs are minimal and should be absorbable within the Division's current appropriation.

Departments Contacted

Regulatory Agencies

Bill E

HOUSE SPONSORSHIP

Spradley, Clapp, and Williams T.

SENATE SPONSORSHIP

McElhany, and Owen

A BILL FOR AN ACT

CONCERNING PROPORTIONAL RATING FOR HEALTH INSURANCE PREMIUMS FOR BUSINESS GROUPS OF ONE.

Bill Summary

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

Task Force to Evaluate Health Care Needs. Allows for a proportional rating model using health screening for business groups of one. Allows an increase or decrease of up to 15% of the carrier's filed rate based on claims experience, health status, or duration of coverage. Allows for premium increases of up to 10% annually based on such factors. Limits the overall rate of change to 5% of the modified community rating filed with the commissioner of insurance (the commissioner). Allows the modified community rating filed with the commissioner to be the maximum rate if the 5% is not met within one year. Requires small group carriers to file with the commissioner semiannual reports on the total premium charged for covered lives by the carrier for the purposes of compliance with the 5% limit.

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

SECTION 1. 10-16-105, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-16-105. Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans - repeal. (8.5) (a) FOR SMALL GROUP HEALTH BENEFIT PLANS ISSUED OR RENEWED TO A BUSINESS GROUP OF ONE ON OR AFTER JANUARY 1, 2003;

(I) AN ADJUSTMENT IN RATES FOR CLAIMS EXPERIENCE, HEALTH STATUS, OR DURATION OF COVERAGE MAY BE MADE BUT SHALL NOT BE CHARGED TO THE INDIVIDUALS UNDER THE PLAN;

(II) FOR A BUSINESS GROUP OF ONE'S POLICY, SUCH ADJUSTMENTS MAY BE MADE BUT SHALL NOT RESULT IN A RATE FOR THE SMALL EMPLOYER THAT DEVIATES MORE THAN FIFTEEN PERCENT FROM THE CARRIER'S FILED RATE;

(III) ANY SUCH ADJUSTMENTS SHALL BE APPLIED UNIFORMLY TO THE RATES CHARGED FOR ALL INDIVIDUALS UNDER THE BUSINESS GROUP OF ONE POLICY; AND

(IV) A SMALL EMPLOYER CARRIER MAY MAKE AN ADJUSTMENT TO A BUSINESS GROUP OF ONE'S RENEWAL PREMIUM, NOT TO EXCEED TEN PERCENT ANNUALLY, DUE TO THE CLAIMS EXPERIENCE, HEALTH STATUS, OR DURATION OF COVERAGE FOR ALL INDIVIDUALS UNDER THE BUSINESS GROUP OF ONE

POLICY.

(b) SMALL GROUP CARRIERS OFFERING A HEALTH BENEFIT PLAN TO A BUSINESS GROUP OF ONE PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (8.5) SHALL REPORT INFORMATION SEMIANNUALLY ON FORMS PRESCRIBED BY THE COMMISSIONER, ENABLING THE COMMISSIONER TO MONITOR THE RELATIONSHIP OF THE AGGREGATE ADJUSTED PREMIUMS ACTUALLY CHARGED TO POLICYHOLDERS BY EACH CARRIER TO THE PREMIUMS THAT WOULD HAVE BEEN CHARGED BY APPLICATION OF THE CARRIER'S MODIFIED COMMUNITY RATES. IF THE AVERAGE RESULTING FROM THE APPLICATION OF SUCH ADJUSTMENT EXCEEDS THE PREMIUM THAT WOULD HAVE BEEN CHARGED BY APPLICATION OF THE AVERAGE MODIFIED COMMUNITY RATE BY MORE THAN FIVE PERCENT OF THE MODIFIED COMMUNITY RATE, THE CARRIER SHALL LIMIT THE APPLICATION OF SUCH ADJUSTMENTS ONLY TO MINUS ADJUSTMENTS BEGINNING ON OR BEFORE THE SIXTIETH DAY AFTER THE REPORT IS SENT TO THE COMMISSIONER. FOR ANY SUBSEQUENT RATING PERIOD, IF THE TOTAL ADJUSTED AGGREGATE PREMIUM ACTUALLY CHARGED DOES NOT EXCEED THE PREMIUM THAT WOULD HAVE BEEN CHARGED BY APPLICATION OF THE MODIFIED COMMUNITY RATE BY MORE THAN FIVE PERCENT OF THE MODIFIED COMMUNITY RATE, THE CARRIER MAY APPLY BOTH PLUS AND MINUS ADJUSTMENTS.

(c) ON AND AFTER JANUARY 1, 2004, SMALL EMPLOYER CARRIERS OFFERING COVERAGE TO BUSINESS GROUPS OF ONE SHALL DEMONSTRATE THAT _____ PERCENT OF BUSINESS GROUPS OF ONE INSUREDS ARE AT OR BELOW THE FILED COMMUNITY INDEX RATE. SUCH DECREASES SHALL CONTINUE UNTIL SUCH SMALL EMPLOYER CARRIERS DEMONSTRATE THAT AT LEAST EIGHTY PERCENT OF THE BUSINESS GROUP OF ONE INSUREDS ARE AT OR BELOW THE FILED COMMUNITY INDEX RATE.

(d) THIS SECTION (8.5) IS REPEALED, EFFECTIVE JANUARY 1, 2009.

SECTION 2. Effective date - applicability. (1) This act shall take effect January 1, 2003, unless a referendum petition is filed during the ninety-day period after final adjournment of the general assembly that is allowed for submitting a referendum petition pursuant to article V, section 1 (3) of the state constitution. If such a referendum petition is filed against this act or an item, section, or part of this act within such period, then the act, item, section, or part shall take effect on the specified date only if approved by the people.

(2) The provisions of this act shall apply to health benefit plans issued or renewed to a business group of one on or after the applicable effective date of this act.

DRAFT

Bill E

Colorado Legislative Council Staff

NO FISCAL IMPACT

Drafting Number:	LLS 02-0110	**Date:**	November 9, 2001
Prime Sponsor(s):	Rep. Spradley Sen. McElhany	**Bill Status:**	Health Care Needs Task Force
		Fiscal Analyst:	Melodie Jones (303-866-4976)

TITLE: CONCERNING PROPORTIONAL RATING FOR HEALTH INSURANCE PREMIUMS FOR BUSINESS GROUPS OF ONE.

Summary of Assessment

This bill authorizes a proportional rating model using health screening for business groups of one and allows: 1) an increase or decrease of up to 15 percent of the carrier's filed rate based on claims experience, health status, or duration of coverage; 2) premium increase of up to 10 percent annually based on such factors; and 3) an overall rate change of no more than 5 percent of the modified community rating filed with the Commissioner of Insurance. Additionally, the bill establishes reporting requirements for small group carriers. The bill is effective January 1, 2003, unless a referendum petition is filed during the 90-day period after final adjournment of the General Assembly.

This bill is assessed as having no state or local fiscal impact. The workload associated with making the necessary rule changes, creating the additional reporting form and analyzing the reports is not significant and can be absorbed within the existing resources of the Division of Insurance, Department of Regulatory Agencies.

Departments Contacted

Regulatory Agencies

Bill F

HOUSE SPONSORSHIP

Owen, Fitz-Gerald, Hagedorn, and Isgar

SENATE SPONSORSHIP

Williams T., Miller, and Spradley

SENATE CONCURRENT RESOLUTION

SUBMITTING TO THE REGISTERED ELECTORS OF THE STATE OF COLORADO AN AMENDMENT TO SECTION 2 OF ARTICLE XI OF THE CONSTITUTION OF THE STATE OF COLORADO, CONCERNING THE AUTHORIZATION FOR LOCAL GOVERNMENTS THAT ARE LAWFULLY AUTHORIZED TO PROVIDE HEALTH CARE TO PARTICIPATE WITH A PUBLIC OR PRIVATE ENTITY IN AFFECTING THE PROVISION OF SUCH HEALTH CARE, AND, IN CONNECTION THEREWITH, AUTHORIZING A COUNTY, CITY, TOWN, TOWNSHIP, OR SPECIAL DISTRICT TO BECOME A SUBSCRIBER, MEMBER, OR SHAREHOLDER IN OR A JOINT OWNER WITH ANY PERSON OR COMPANY, PUBLIC OR PRIVATE, IN ORDER TO PROVIDE SUCH HEALTH CARE WITHOUT INCURRING DEBT AND WITHOUT PLEDGING ITS CREDIT OR FAITH; REQUIRING ANY SUCH COUNTY, CITY, TOWN, TOWNSHIP, OR SPECIAL DISTRICT ENTERING SUCH AN ARRANGEMENT TO OWN ITS JUST PROPORTION TO THE WHOLE AMOUNT INVESTED; AND PROVIDING THAT ANY SUCH ENTITY OR RELATIONSHIP ESTABLISHED FOR SUCH PURPOSE SHALL NOT BE DEEMED A POLITICAL SUBDIVISION, LOCAL GOVERNMENT, OR LOCAL PUBLIC BODY FOR ANY PURPOSE.

Resolution Summary

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

Task Force to Evaluate Health Care Needs. Allows a local government authorized to provide any health care function, service, or facility to be joint owner with, shareholder in, or member of any public or private entity in order to affect the provision of such function, service, or facility if such local government does not incur debt or pledge its credit or faith. Requires a local government to own its just proportion of such arrangement. Specifies that any private entity or relationship established for such purpose shall not be deemed a political subdivision, local government, or local public body for such purpose.

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

SECTION 1. At the next election at which such question may be submitted, there shall be submitted to the registered electors of the state of Colorado, for their approval or rejection, the following amendment to the constitution of the state of Colorado, to wit:

Section 2 of article XI of the constitution of the state of Colorado is amended to read:

Section 2. No aid to corporations - no joint ownership by state, county, city, town, or school district. (1) Neither the state, nor any county, city, town, township, or school district shall make any donation or grant to, or in aid of, or become a subscriber to, or shareholder in any corporation or

company or a joint owner with any person, company, or corporation, public or private, in or out of the state, except as to such ownership as may accrue to the state by escheat, or by forfeiture, by operation or provision of law; and except as to such ownership as may accrue to the state, or to any county, city, town, township, or school district, or to either or any of them, jointly with any person, company, or corporation, by forfeiture or sale of real estate for nonpayment of taxes, or by donation or devise for public use, or by purchase by or on behalf of any or either of them, jointly with any or either of them, under execution in cases of fines, penalties, or forfeiture of recognizance, breach of condition of official bond, or of bond to secure public moneys, or the performance of any contract in which they or any of them may be jointly or severally interested.

(2) Nothing in this section shall be construed to prohibit any city or town from becoming a subscriber or shareholder in any corporation or company, public or private, or a joint owner with any person, company, or corporation, public or private, in order to effect the development of energy resources after discovery, or production, transportation, or transmission of energy in whole or in part for the benefit of the inhabitants of such city or town.

(3) NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PROHIBIT ANY COUNTY, CITY, TOWN, TOWNSHIP, OR SPECIAL DISTRICT LAWFULLY AUTHORIZED TO PROVIDE ANY HEALTH CARE FUNCTION, SERVICE, OR FACILITY FROM BECOMING A SUBSCRIBER, MEMBER, OR SHAREHOLDER IN ANY CORPORATION, COMPANY, OR OTHER ENTITY, PUBLIC OR PRIVATE, OR A JOINT OWNER WITH ANY PERSON, COMPANY, CORPORATION, OR OTHER ENTITY, PUBLIC OR PRIVATE, IN OR OUT OF THE STATE, IN ORDER TO AFFECT THE PROVISION OF SUCH FUNCTION, SERVICE, OR FACILITY IN WHOLE OR IN PART. IN ANY SUCH CASE, THE PRIVATE PERSON, COMPANY, CORPORATION, OR ENTITY OR RELATIONSHIP ESTABLISHED SHALL NOT BE DEEMED A POLITICAL SUBDIVISION, LOCAL GOVERNMENT, OR LOCAL PUBLIC BODY FOR ANY PURPOSE. ANY SUCH COUNTY, CITY, TOWN, TOWNSHIP, OR SPECIAL DISTRICT THAT ENTERS INTO AN ARRANGEMENT UNDER THIS SECTION SHALL NOT INCUR ANY DEBT NOR PLEDGE ITS CREDIT OR FAITH UNDER SUCH ARRANGEMENT. ANY COUNTY, CITY, TOWN, TOWNSHIP, OR SPECIAL DISTRICT ENTERING INTO SUCH JOINT OWNERSHIP OR RELATIONSHIP AS SUBSCRIBER, MEMBER, OR SHAREHOLDER OR OTHERWISE SHALL OWN ITS JUST PROPORTION TO THE WHOLE AMOUNT SO INVESTED. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO LIMIT THE POWERS, DUTIES, OR AUTHORITY OF ANY POLITICAL SUBDIVISION AS OTHERWISE PROVIDED OR AUTHORIZED BY LAW. NOTHING IN THIS SUBSECTION (3) SHALL BE CONSTRUED TO LIMIT THE POWERS OF THE GENERAL ASSEMBLY OVER THE PROVISION OF ANY HEALTH CARE FUNCTION, SERVICE, OR FACILITY BY ANY COUNTY, CITY, TOWN, TOWNSHIP, OR SPECIAL DISTRICT.

SECTION 2. Each elector voting at said election and desirous of voting for or against said amendment shall cast a vote as provided by law either "Yes" or "No" on the proposition: "AN AMENDMENT TO SECTION 2 OF ARTICLE XI OF THE CONSTITUTION OF THE STATE OF COLORADO, CONCERNING THE AUTHORIZATION FOR LOCAL GOVERNMENTS THAT ARE LAWFULLY AUTHORIZED TO PROVIDE HEALTH CARE TO PARTICIPATE WITH A PUBLIC OR PRIVATE ENTITY IN AFFECTING THE PROVISION OF SUCH HEALTH CARE, AND, IN CONNECTION THEREWITH, AUTHORIZING A COUNTY, CITY, TOWN, TOWNSHIP, OR SPECIAL DISTRICT TO BECOME A SUBSCRIBER, MEMBER, OR SHAREHOLDER IN OR A JOINT OWNER WITH ANY PERSON OR COMPANY, PUBLIC OR PRIVATE, IN ORDER TO PROVIDE SUCH HEALTH CARE WITHOUT INCURRING DEBT AND WITHOUT PLEDGING ITS CREDIT OR FAITH; REQUIRING ANY SUCH COUNTY, CITY, TOWN, TOWNSHIP, OR SPECIAL DISTRICT ENTERING SUCH AN ARRANGEMENT TO OWN ITS JUST PROPORTION TO THE WHOLE AMOUNT INVESTED; AND PROVIDING THAT ANY SUCH ENTITY OR RELATIONSHIP ESTABLISHED FOR SUCH PURPOSE SHALL NOT BE DEEMED A POLITICAL SUBDIVISION, LOCAL GOVERNMENT, OR LOCAL PUBLIC BODY FOR ANY PURPOSE."

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

DRAFT

Bill F

Colorado Legislative Council Staff

LOCAL
CONDITIONAL FISCAL IMPACT

No State General Fund Impact

Drafting Number:	LLS 02-0111	**Date:**	November 21, 2001
Prime Sponsor(s):	Sen. Owen Rep. Williams T.	**Bill Status:**	Health Care Needs Task Force
		Fiscal Analyst:	Melodie Jones (303-866-8151)

TITLE: SUBMITTING TO THE REGISTERED ELECTORS OF THE STATE OF COLORADO AN AMENDMENT TO SECTION 2 OF ARTICLE XI OF THE CONSTITUTION OF THE STATE OF COLORADO, CONCERNING THE AUTHORIZATION FOR LOCAL GOVERNMENTS THAT ARE LAWFULLY AUTHORIZED TO PROVIDE HEALTH CARE TO PARTICIPATE WITH A PUBLIC OR PRIVATE ENTITY IN AFFECTING THE PROVISION OF SUCH HEALTH CARE, AND, IN CONNECTION THEREWITH, AUTHORIZING A COUNTY, CITY, TOWN, TOWNSHIP, OR SPECIAL DISTRICT TO BECOME A SUBSCRIBER, MEMBER, OR SHAREHOLDER IN OR A JOINT OWNER WITH ANY PERSON OR COMPANY, PUBLIC OR PRIVATE, IN ORDER TO PROVIDE SUCH HEALTH CARE WITHOUT INCURRING DEBT AND WITHOUT PLEDGING ITS CREDIT OR FAITH; REQUIRING ANY SUCH COUNTY, CITY, TOWN, TOWNSHIP, OR SPECIAL DISTRICT ENTERING SUCH AN AGREEMENT TO OWN ITS JUST PROPORTION TO THE WHOLE AMOUNT INVESTED; AND PROVIDING THAT ANY SUCH ENTITY OR RELATIONSHIP ESTABLISHED FOR SUCH PURPOSE SHALL NOT BE DEEMED A POLITICAL SUBDIVISION, LOCAL GOVERNMENT, OR LOCAL PUBLIC BODY FOR ANY PURPOSE.

Fiscal Impact Summary	FY 2002/2003	FY 2003/2004
State Revenues Cash Fund	$0	$0
State Expenditures Cash Fund	$0	$0
FTE Position Change	0.0 FTE	0.0 FTE
Other State Impact: None		
Effective Date: The resolution would become effective subject to approval of the voters at the 2002 General Election		
Appropriation Summary for FY 2002/2003: None		
Local Government Impact: Cannot be determined at this time.		

Summary of Legislation

This concurrent resolution submits a constitutional amendment to the people at the 2002 General Election that allows any local government entity authorized to provide health care functions, services or facilities to be a joint owner with, shareholder in, or members of any public or private entity in order to perform such functions, services, or facilities. Local government entities are prohibited from incurring debt or pledging their credit or faith under such arrangements and are required to own their just proportion when entering into such arrangements. Any private entity or relationship established for such purpose shall not be deemed a political subdivision, local government, or local public body for such purpose.

Election Expenditure Impacts *(for informational purposes only)*

Because this concurrent resolution is a ballot issue, the measure will be published in newspapers and an analysis of the measure will be included in the Blue Book mailed to all registered voter households prior to the election. Under current law, costs for these functions are paid through a General Fund line item in the Long Appropriation Bill.

The estimated 2002 General Election costs for the Blue Book are outlined in Table 1.

Table 1. Estimated Costs of Producing the 2002 Blue Book and Distributing to all Registered Voter Households	
Printing	$250,000
Postage	275,000
Translation	20,000
Newspaper Publication (English & Spanish)	1,000,000
Total Expenses (estimated for 14 issues)	$1,545,000
Estimated Expense Per Issue	$110,357

Local Government Impact

This concurrent resolution is assessed as having a conditional local fiscal impact. The impact to local expenditures or revenues is dependent on the number, if any, of local government entities that choose to enter into joint ownership and operation of a health care function, service or facility with a private or other public entity. Because the number and nature of these arrangements are unknown, the impact can not be quantified.

State Appropriations

No appropriation is required in FY 2002-03.

Departments Contacted

Public Health and Environment Local Affairs

Bill G

HOUSE SPONSORSHIP

Hagedorn

SENATE SPONSORSHIP

Spradley

A BILL FOR AN ACT

CONCERNING THE DEFINITION OF BASIC HEALTH BENEFIT COVERAGE.

Bill Summary

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

Task Force to Evaluate Health Care Needs. Clarifies the definition of a basic health benefit plan for a small employer group. Exempts such plans from certain mandatory coverage provisions. Makes conforming amendments.

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

SECTION 1. 10-16-105 (7.2), Colorado Revised Statutes, is amended to read:

10-16-105. Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans. (7.2) The commissioner shall promulgate rules to implement a basic health benefit plan and a standard health benefit plan to be offered by each small employer carrier as a condition of transacting business in this state. Such rules shall be ~~effective January 1, 1995, and~~ in conformity with the provisions of article 4 of title 24, C.R.S. SUCH RULES SHALL REFLECT THE FOLLOWING:

(a) THE STANDARD HEALTH BENEFIT PLAN SHALL REFLECT THE BENEFIT DESIGN OF COMMON PLAN OFFERINGS IN THE SMALL GROUP MARKET; AND

(b) THE BASIC HEALTH BENEFIT PLAN SHALL REFLECT THE BENEFIT DESIGN OF CATASTROPHIC COVERAGE AS DEFINED IN SECTION 10-16-116; EXCEPT THAT HEALTH MAINTENANCE ORGANIZATION BASIC HEALTH BENEFIT PLANS SHALL REFLECT A SHARING OF HIGHER CONSUMER COSTS THROUGH HIGHER COPAYMENTS INSTEAD OF DEDUCTIBLE AMOUNTS.

SECTION 2. 10-16-104 (1) (a), (1.7), and (4), the introductory portion to 10-16-104 (5), 10-16-104 (5.5) (a) (I) and (8) (b), the introductory portions to 10-16-104 (9) (a) and (10) (a), 10-16-104 (11) (b), the introductory portion to 10-16-104 (12) (a), and 10-16-104 (13) (a) and (14) (a), Colorado Revised Statutes, are amended to read:

10-16-104. Mandatory coverage provisions. (1) **Newborn children.** (a) All group and individual sickness and accident insurance policies ISSUED

BY AN ENTITY SUBJECT TO PART 2 OF THIS ARTICLE and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article, NOT INCLUDING BASIC HEALTH BENEFIT PLANS, shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(1.7) **Therapies for congenital defects and birth abnormalities.** (a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans, NOT INCLUDING BASIC HEALTH BENEFIT PLANS, shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children up to five years of age.

(4) **Low-dose mammography.** (a) For the purposes of this subsection (4), "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and film and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. All individual and all group sickness and accident insurance policies, except BASIC HEALTH BENEFIT PLANS AND supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage provided to residents of this state, shall provide coverage for routine and certain diagnostic screening by low-dose mammography for the presence of breast cancer in adult women. Routine and diagnostic screenings provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar year basis by entities subject to part 2 or 3 of this article and shall not be subject to policy deductibles. Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index. Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, which shall be specified in the policy or contract. The routine and diagnostic coverages provided pursuant to this subsection (4) shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. If an insured person who is eligible for a routine mammography screening benefit pursuant to subparagraphs (I), (II), and (III) of this paragraph

(a), has not utilized such benefit during a calendar year or a contract year, then such provisions shall apply to one diagnostic screening for such year. If more than one diagnostic screening is provided for such person in a given calendar year or contract year, the other diagnostic service benefit provisions in the policy or contract shall apply with respect to such additional screenings. This mandated mammography coverage shall be provided according to the following guidelines:

(5) **Mental illness.** Every group policy or contract providing hospitalization or medical benefits by an entity subject to the provisions of part 2 or 3 of this article EXCEPT BASIC HEALTH BENEFIT PLANS shall provide benefits for conditions arising from mental illness at least equal to the following:

(5.5) **Biologically based mental illness.** (a) (I) Every group policy, plan certificate, and contract of a carrier subject to the provisions of part 2, 3, or 4 of this article, except BASIC HEALTH BENEFIT PLANS AND those described in section 10-16-102 (21) (b), shall provide coverage for the treatment of biologically based mental illness that is no less extensive than the coverage provided for any other physical illness. Any preauthorization or utilization review mechanism used in the determination to provide such coverage shall be the same as, or no more restrictive than, that used in the determination to provide coverage for any other physical illness. The commissioner shall adopt such rules as are necessary to carry out the provisions of this subsection (5.5). In promulgating such rules, the commissioner shall recognize that the substance of the mechanisms for preauthorization or utilization review may differ between medical specialities and that such mechanisms shall not be more restrictive with respect to a covered person or a mental health provider for a determination under this subparagraph (I) than for any other physical illness.

(8) **Availability of hospice care coverage.** (b) Notwithstanding any other provision of the law to the contrary, no individual or group policy of sickness and accident insurance issued by an insurer subject to the provisions of part 2 of this article and no plan issued by an entity subject to the provisions of part 3 of this article which provides hospital, surgical, or major medical coverage on an expense incurred basis EXCEPT BASIC HEALTH BENEFIT PLANS shall be sold in this state unless a policyholder under such policy or plan is offered the opportunity to purchase coverage for benefits for the costs of home health services and hospice care which have been recommended by a physician as medically necessary. Nothing in this paragraph (b) shall require an insurer to offer coverages for which premiums would not cover expected benefits. This

paragraph (b) shall not apply to any insurance policy, plan, contract, or certificate which provides coverage exclusively for disability loss of income, dental services, optical services, hospital confinement indemnity, accident only, or prescription drug services.

(9) **Availability of coverage for alcoholism.** (a) Any other provision of law to the contrary notwithstanding, no hospitalization or medical benefits contract on a group basis issued by an insurer subject to the provisions of part 2 of this article or an entity subject to the provisions of part 3 of this article EXCEPT BASIC HEALTH BENEFIT PLANS shall be sold in this state unless the policyholder under such contract or persons holding the master contract under such contract are offered the opportunity to purchase coverage for benefits for the treatment of and for conditions arising from alcoholism, which benefits are at least equal to the following minimum requirements:

(10) **Prostate cancer screening.** (a) All individual and all group sickness and accident insurance policies, except BASIC HEALTH BENEFIT PLANS AND supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, shall provide coverage for annual screening for the early detection of prostate cancer in men over the age of fifty years and in men over the age of forty years who are in high-risk categories, which coverage by entities subject to part 2 or 3 of this article shall not be subject to policy deductibles. Such coverage shall be the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening. Such benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. This coverage shall be provided according to the following guidelines:

(11) (b) An individual HEALTH BENEFIT PLAN, A small group HEALTH BENEFIT PLAN OTHER THAN A BASIC HEALTH BENEFIT PLAN, or A large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. Each such plan shall, at a minimum, provide benefits for preventive child health supervision services. A plan described in this paragraph (b) may provide that child health supervision services rendered during a periodic review shall only be covered to the extent such services are provided

during the course of one visit by or under the supervision of a single physician, physician's assistant, or registered nurse.

(12) **Hospitalization and general anesthesia for dental procedures for dependent children.** (a) All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article except BASIC HEALTH BENEFIT PLANS AND supplemental policies that cover a specific disease or other limited benefit shall provide coverages for general anesthesia, when rendered in a hospital, outpatient surgical facility, or other facility licensed pursuant to section 25-3-101, C.R.S., and for associated hospital or facility charges for dental care provided to a dependent child, as dependent is defined in section 10-16-102 (14), of a covered person. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:

(13) **Diabetes.** (a) Any health benefit plan, except BASIC HEALTH BENEFIT PLANS AND supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for diabetes that shall include equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items pursuant to Colorado law, and, if coverage is provided through a managed care plan, such qualified provider shall be a participating provider in such managed care plan.

(14) **Prosthetic devices.** (a) Any health benefit plan, except BASIC HEALTH BENEFIT PLANS AND supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. secs. 1395k, 1395l, and 1395m and 42 CFR 414.202, 414.210, 414.228, and 410.100, as applicable to this subsection (14).

SECTION 3. 10-16-116 (2) (h), Colorado Revised Statutes, is amended to read:

10-16-116. Catastrophic health insurance - coverage. (2) Each catastrophic health insurance policy issued pursuant to subsection (1) of this section is required to:

(h) For group coverage, include a portability clause which provides that

~~(I)~~ when an employee leaves employment for any reason the employee, the employee's spouse, and the employee's dependent children may each elect to continue coverage or convert coverage to an individual policy pursuant to section 10-16-108. ~~and~~

~~(II) Conversion benefits shall be the insured's choice of the same coverage issued, without evidence of insurability, as an individual policy or the conversion coverage specified in section 10-16-108;~~

SECTION 4. Effective date - applicability. (1) This act shall take effect January 1, 2003, unless a referendum petition is filed during the ninety-day period after final adjournment of the general assembly that is allowed for submitting a referendum petition pursuant to article V, section 1 (3) of the state constitution. If such a referendum petition is filed against this act or an item, section, or part of this act within such period, then the act, item, section, or part shall take effect on the specified date only if approved by the people.

(2) The provisions of this act shall apply to health benefit plans issued or renewed on or after the applicable effective date of this act.

DRAFT

Bill G

Colorado Legislative Council Staff

NO FISCAL IMPACT

Drafting Number:	LLS 02-0112	**Date:**	October 30, 2001
Prime Sponsor(s):	Sen. Hagedorn Rep. Spradley	**Bill Status:**	Health Care Needs Task Force
		Fiscal Analyst:	Melodie Jones (303-866-4976)

TITLE: CONCERNING ALTERNATIVE HEALTH BENEFIT COVERAGE FOR SMALL EMPLOYERS.

Summary of Assessment

This bill requires that basic health plans in the small group market be catastrophic policy plans. The bill also exempts basic health benefit plans from the following mandatory coverages: 1) newborn children; 2) physical, occupation, and speech therapy care and treatment of congenital defects and birth abnormalities; 3) low-dose mammography; 4) mental illness; 5) biologically-based mental illness; 6) hospice care; 7) alcoholism; 8) prostate cancer screening; 9) hospitalization and general anesthesia for dental procedures for dependent children; 10) diabetes; and 11) prosthetic devices. The bill is effective January 1, 2003 unless a referendum petition is filed 90 days after final adjournment.

This bill is assessed as having no fiscal impact. Although the bill requires amendments to the Division of Insurance's regulations, this will not add a significant increase to the Division of Insurance's workload.

Departments Contacted

Regulatory Agencies

Bill H

HOUSE SPONSORSHIP

Isgar, Fitz-Gerald, Hagedorn, McElhany, and Owen

SENATE SPONSORSHIP

Tochtrop and Miller

A BILL FOR AN ACT

CONCERNING PROMPT PAYMENT OF HEALTH INSURANCE CLAIMS.

Bill Summary

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

Task Force to Evaluate Health Care Needs. Requires the commissioner of insurance ("commissioner") to adopt uniform health care claim forms and standardized billing codes to be used by all health care providers in the state by July 1, 2002. Requires the commissioner to consult with the centers for medicare and medicaid services and the national association of insurance commissioners when adopting such forms and codes.

Requires all insurance companies to accept uniform health insurance claim forms from health care providers in electronic form by October 1, 2002. Requires all insurance companies to provide an acknowledgment to an insured or a health care provider upon receipt of a claim. Requires all insurance companies to notify a claimant within 30 days after receipt of a claim when the claim is held due to delinquent premiums.

Requires all electronic health insurance claims to be paid, denied, or settled within 63 days after initial receipt by the carrier and all hard-copy claims to be paid, denied, or settled within 78 days after initial receipt by the carrier. In cases where an insurer fails to comply with these requirements, establishes a penalty of 10% of the total amount ultimately allowed on the claim. Assesses an additional penalty equal to 20% of a claim for demonstrating a pattern of noncompliance with these requirements.

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

SECTION 1. Article 16 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-106.3. Uniform claims - billing codes - electronic claim forms. (1) ON OR BEFORE JULY 1, 2002, THE COMMISSIONER SHALL ADOPT:

(a) UNIFORM HEALTH CARE CLAIM FORMS FOR USE BY ALL HEALTH CARE PROVIDERS AND CARRIERS IN THE STATE;

(b) UNIFORM STANDARDS AND PROCEDURES FOR PROCESSING SUCH CLAIM FORMS IN ELECTRONIC AND HARD-COPY FORM; AND

(c) STANDARDIZED BILLING CODES FOR USE ON THE UNIFORM HEALTH CARE CLAIM FORMS.

(2) THE COMMISSIONER SHALL CONSULT WITH THE DIRECTOR OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS WHEN ADOPTING THE UNIFORM CLAIM FORMS AND THE STANDARDIZED BILLING CODES.

(3) ON OR BEFORE OCTOBER 1, 2002, ALL INSURANCE COMPANIES SHALL ACCEPT THE UNIFORM HEALTH INSURANCE CLAIM FORMS ADOPTED PURSUANT TO THIS SECTION FROM HEALTH CARE PROVIDERS IN ELECTRONIC FORM AND SHALL NOT REQUIRE THE SUBMISSION OF HEALTH CARE CLAIMS IN

HARD-COPY FORM.

SECTION 2. 10-16-106.5 (2), (4) (b), (4) (c), and (5) (b), Colorado Revised Statutes, are amended, and the said 10-16-106.5 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

10-16-106.5. Prompt payment of claims - legislative declaration. (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the ~~carrier's standard~~ UNIFORM claim form ADOPTED PURSUANT TO SECTION 10-16-106.3 with all required fields completed with correct and complete information in accordance with the carrier's published filing requirements. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law. IF A CARRIER HOLDS A CLAIM DUE TO DELINQUENT PREMIUMS, THE CARRIER SHALL PROVIDE WRITTEN NOTICE TO THE PROVIDER, POLICYHOLDER, INSURED, OR PATIENT, AS APPROPRIATE, WITHIN THIRTY DAYS AFTER RECEIPT OF THE CLAIM THAT SUCH CLAIM IS BEING HELD DUE TO DELINQUENT PREMIUMS.

(2.7) (a) EVERY CARRIER, UPON RECEIPT OF AN ELECTRONIC CLAIM, SHALL PROVIDE THE PROVIDER, POLICYHOLDER, INSURED, OR PATIENT, AS APPROPRIATE, WITH AN ACKNOWLEDGMENT OF THE RECEIPT OF THE CLAIM IN ELECTRONIC FORM WITHIN TWO BUSINESS DAYS.

(b) EVERY CARRIER, UPON RECEIPT OF A HARD-COPY CLAIM, SHALL PROVIDE THE PROVIDER, POLICYHOLDER, INSURED, OR PATIENT, AS APPROPRIATE, WITH AN ACKNOWLEDGMENT OF THE RECEIPT OF THE CLAIM IN HARD-COPY FORM WITHIN TEN BUSINESS DAYS.

(4) (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation of what additional information is needed. The person receiving a request for additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. IF SUCH PERSON HAS PROVIDED ALL THE REQUESTED INFORMATION, THE CLAIM SHALL BE TREATED AS A CLEAN CLAIM. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider fails to timely submit additional information requested under this paragraph (b). AFTER THE SUBMISSION OF THE REQUESTED ADDITIONAL INFORMATION, THE CLAIM SHALL BE PAID, DENIED, OR SETTLED BY THE CARRIER WITHIN THE APPLICABLE TIME PERIOD SET FORTH IN PARAGRAPH (c) OF THIS SUBSECTION (4).

(c) Absent fraud, all claims except those described in paragraph (a) of

this subsection (4) shall be paid, denied, or settled within ~~ninety~~ SIXTY-THREE calendar days, IN THE CASE OF ELECTRONIC CLAIMS, OR SEVENTY-EIGHT DAYS, IN THE CASE OF HARD-COPY CLAIMS, after receipt by the carrier OF ALL REQUIRED INFORMATION.

(5) (b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ~~ninety~~ SIXTY-THREE days after receiving the ELECTRONIC claim OR SEVENTY-EIGHT DAYS AFTER RECEIVING A HARD-COPY CLAIM shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ~~three~~ TEN percent of the total amount ultimately allowed on the claim. Such penalty shall be due on the ~~ninety-first~~ SIXTY-FOURTH day after receipt of the ELECTRONIC claim AND THE SEVENTY-NINTH DAY AFTER RECEIPT OF A HARD-COPY CLAIM by the carrier.

SECTION 3. 10-16-106.5 (5), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

10-16-106.5. Prompt payment of claims - legislative declaration.

(5) (c) ANY CARRIER THAT DEMONSTRATES A PATTERN OF NONCOMPLIANCE WITH PARAGRAPH (a) OR (b) OF THIS SUBSECTION (5) SHALL PAY TO THE INSURED OR HEALTH CARE PROVIDER, WITH PROPER ASSIGNMENT, AN ADDITIONAL PENALTY FOR EACH EPISODE OF NONCOMPLIANCE IN AN AMOUNT EQUAL TO TWENTY PERCENT OF THE TOTAL AMOUNT ULTIMATELY OWED ON THE CLAIM. THE DIVISION OF INSURANCE SHALL ENFORCE THIS SUBSECTION (5).

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

DRAFT

Colorado Legislative Council Staff

NO FISCAL IMPACT

Drafting Number:	LLS 02-0113	**Date:**	November 9, 2001
Prime Sponsor(s):	Sen. Isgar	**Bill Status:**	Health Care Needs Task Force
	Rep. Tochtrop	**Fiscal Analyst:**	Melodie Jones

TITLE: CONCERNING PROMPT PAYMENT OF HEALTH INSURANCE CLAIMS.

Summary of Assessment

The bill requires the Commissioner of Insurance to adopt uniform health care claim forms and standardized billing codes to be used by all health care providers by July 1, 2002. Insurance companies are required to:

- accept uniform health insurance claim forms from health care providers in electronic form by October 1, 2002;
- provide acknowledgment to an insured or health care provider upon receipt of a claim; and
- notify a claimant within 30 days after receipt of a claim when it is held due to delinquent premiums.

The bill decreases the time allowed for claims that require additional information to be paid, denied, or settled from 90 days to 63 days for electronic copies and 78 days for hard-copy claims. The bill also increases the penalty for failure to settle the claim within the established time frames from three percent to 10 percent of the total amount allowed on the claim and establishes a new penalty of 20 percent if the insurance company demonstrates a pattern of noncompliance with the established time frames.

National standards for billing codes and electronic transmission of health care claim data have been established under the federal rules for the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Compliance with these rules by large health plans is required by October 16, 2002, and for small health plan carriers by October 16, 2003.

While this bill may impact small group insurance carriers by mandating all insurance companies to accept electronic claim forms by October 1, 2002 (a year before small carriers are required to under HIPAA), the bill is assessed as having no state or local fiscal impact. Since the national standards were adopted on October 16, 2000, the Division of Insurance's, Department of Regulatory Agencies, workload will not increase significantly to develop the uniform claim forms and the standardized billing codes required in this bill. Furthermore, the division will be able to enforce the bill's penalties for non-compliance within existing resources.

Departments Contacted

Regulatory Agencies Health Care Policy and Finance

Bill I

HOUSE SPONSORSHIP

Williams T., Miller, and Spradley

SENATE SPONSORSHIP

(None)

A BILL FOR AN ACT

CONCERNING THE LIMITATION OF CONTINGENCY FEE AGREEMENTS IN MEDICAL MALPRACTICE ACTIONS.

Bill Summary

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

Task Force to Evaluate Health Care Needs. Limits the amount that an attorney may charge on a contingency fee agreement for medical malpractice actions to 20%. Does not allow an attorney to recover any contingency amount on medical expenses that have been paid in the past, are being paid, or may be paid in the future.

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

SECTION 1. Article 64 of title 13, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PART to read:

PART6

LIMITATIONS ON MEDICAL MALPRACTICE ACTIONS

13-64-601. Attorney fees for medical malpractice cases - breach of fiduciary duty. (1) **Attorney fees.** FOR ANY MEDICAL MALPRACTICE ACTION FILED ON OR AFTER AUGUST 15, 2002, A CONTINGENT FEE EXCEEDING TWENTY PERCENT OF THE AMOUNT OF ANY SETTLEMENT OR AWARD SHALL BE PRESUMED TO BE UNREASONABLE. IN DETERMINING THE AMOUNT OF DAMAGES SUBJECT TO THE TWENTY PERCENT CONTINGENCY FEE, DAMAGES RECEIVED FOR PAST MEDICAL EXPENSES, MEDICAL EXPENSES BEING PAID, AND FUTURE MEDICAL EXPENSES TO BE PAID SHALL NOT BE INCLUDED. IF THE COURT FINDS THAT AN ATTORNEY REASONABLY DEVOTED AN EXTRAORDINARY AMOUNT OF TIME TO THE CASE, THE COURT MAY AWARD OR APPROVE A CONTINGENT FEE OR OTHER FEE IN A PERCENTAGE OR AMOUNT THAT EXCEEDS TWENTY PERCENT OF ANY SETTLEMENT OR JUDGMENT.

(2) ANY ATTORNEY WHO REPRESENTS ANY PARTY IN A MEDICAL MALPRACTICE CASE SHALL PROVIDE THE PARTY WITH A WRITTEN FEE AGREEMENT THAT SETS FORTH, IN FULL, THE ATTORNEY'S SPECIFIC FEE ARRANGEMENT, INCLUDING THE CRITERIA UPON WHICH THE ATTORNEY BASES HIS OR HER HOURLY OR SET FEE AND THE CIRCUMSTANCES IN WHICH ANY MODIFICATIONS OR ADJUSTMENTS TO SUCH FEE WILL BE MADE, AND SPECIFYING WHETHER THE CLIENT WILL BE CHARGED FOR THE ATTORNEY'S EXPENSES OR

ADVANCES MADE BY THE ATTORNEY ON BEHALF OF THE PARTY, INCLUDING WITHOUT LIMITATION COSTS OF COPYING, RESEARCH, TELEPHONE CALLS, POSTAGE, AND ANY OTHER EXPENSES INCIDENT TO THE LITIGATION THAT THE ATTORNEY MAY BE ETHICALLY BOUND TO UNDERTAKE ON BEHALF OF THE PARTY PURSUANT TO LAW OR PURSUANT TO ANY COURT RULE INCLUDING THE CODE OF PROFESSIONAL RESPONSIBILITY AS ADOPTED BY THE SUPREME COURT OF COLORADO. CONTINGENT FEE AGREEMENTS SHALL BE IN CONFORMITY WITH ALL APPLICABLE PROVISIONS OF THE SAID CODE OR OF RULES OF THE SUPREME COURT, AND, IN ADDITION, SUCH AGREEMENTS SHALL SET FORTH THE PROVISIONS OF THIS SECTION IN EASY TO UNDERSTAND LANGUAGE IN AT LEAST TEN-POINT BOLD-FACED TYPE. NO SUCH FEE AGREEMENT MAY BE ENFORCED AGAINST ANY PARTY UNLESS IT COMPLIES WITH THE REQUIREMENTS OF THIS SECTION AND IS SIGNED BY BOTH PARTIES.

SECTION 2. Effective date - applicability. (1) This act shall take effect August 15, 2002, unless a referendum petition is filed during the ninety-day period after final adjournment of the general assembly that is allowed for submitting a referendum petition pursuant to article V, section 1 (3) of the state constitution. If such a referendum petition is filed against this act or an item, section, or part of this act within such period, then the act, item, section, or part, if approved by the people, shall take effect on the date of the official declaration of the vote thereon by proclamation of the governor.

(2) The provisions of this act shall apply to all actions alleging medical malpractice that are filed on and after the applicable effective date of this act.

DRAFT

Colorado Legislative Council Staff

STATE FISCAL IMPACT

Drafting Number: LLS 02-0126
Prime Sponsor(s): Rep. Williams T.

Date: November 15, 2001
Bill Status: Health Care Needs Task Force
Fiscal Analyst: Melodie Jones (303-866-4976)

TITLE: CONCERNING MEDICAL MALPRACTICE ACTIONS AGAINST HEALTH CARE PROVIDERS.

Fiscal Impact Summary	FY 2002/2003	FY 2003/2004
State Revenues General Fund	$0	$0
State Expenditures General Fund	$0	$77,354
FTE Position Change	0.0 FTE	1.2 FTE
Other State Impact: None		
Effective Date: August 15, 2002, unless a referendum petition is filed during the 90-day period after final adjournment of the General Assembly.		
Appropriation Summary for FY 2002/2003: No appropriation necessary		
Local Government Impact: None		

Summary of Legislation

The bill limits an attorney's contingency fee for medical malpractice actions filed to no more than 20 percent of the settlement amount. Damages received for past, current and future medical expenses shall not be included in determining the amount of damages subject to the 20 percent contingency fee. The court may award or approve a contingency fee or other fee in excess of 20 percent if it determines that the attorney has devoted an extraordinary amount of time to the case.

State Expenditures

The bill is assessed as having a fiscal impact, however no appropriation is required in FY 2002-03. Medical malpractice cases usually take several months from the time of filing to the time when settlement or judgment is reached. Because the bill only affects medical malpractice cases filed on or after August 15, 2002, it is unlikely that many of these cases will reach settlement or judgment prior to FY 2003-04. However, the bill is likely to increase court caseloads in future fiscal years

because the bill allows attorneys to appeal the 20 percent fee cap. This note assumes that a majority of plaintiff attorneys prevailing in the settlement or judgment will appeal the 20 percent cap. Based on this assumption, an additional 600 hours of court hearings will occur. This results in the following costs:

Table 1: Future Fiscal Year Caseload Cost Increases		
	FY 2003-04	On-going
Personal Services	$51,687	$51,687
Operating Expenses	2,145	2,145
Capital Outlay	23,522	0
Total Expenses	**$77,354**	**$53,832**
FTE	**1.2**	**1.2**

These costs are based on current year figures and the following assumptions:

- Approximately 188 medical malpractice cases are filed on an annual basis. This assumption is based on the five year average from FY 1996 to FY 2000.
- The median amount of time it takes to settle or adjudicate a medical malpractice case is between 12 to18 months from the time the claim is made. This assumption is based on the disposition of cases in FY 2000-01.
- The plaintiff will prevail in approximately 40 percent of the cases filed either in settlement or judgement. National claims data suggests that 60 percent of the medical malpractice cases are dismissed or withdrawn in favor of the defendant.
- When the plaintiff prevails, the attorney will appeal the 20 percent contingency fee cap as provided for in the bill. The review of the attorney's fee will require a one-day hearing, resulting in an additional 600 hours of court hearings a year. The assumption that all prevailing attorneys will appeal the fee cap is based on the complexity of medical malpractice cases and a contingency fee cap lower than all other states. Currently, 16 states have statutory caps on attorney contingency fees for medical malpractice cases. Of these 16 states, 11 states have graduated fee caps and five states have flat fee caps. Of the five states with flat fee caps, the lowest flat cap is 33.3 percent and majority of the states with graduated fee caps start at 33.3 percent or higher.
- The 600 hours will require a total 1.2 FTE (0.3 Magistrate, 0.3 Division Clerk, 0.3 Assistant Division Clerk and 0.3 Court Clerk II).

State Appropriations

No appropriation clause is necessary since the impact of the bill is not expected until after FY 2002-03.

Departments Contacted

Judicial

Bill J

HOUSE SPONSORSHIP

Spradley, Clapp, Tochtrop, and Williams T.

SENATE SPONSORSHIP

Hagedorn, and Owen

A BILL FOR AN ACT

CONCERNING EXPANDED ACCESS TO HEALTH INSURANCE.

Bill Summary

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

Task Force to Evaluate Health Care Needs. Allows a health insurance carrier to cross state lines to comply with existing requirements for network adequacy.

Allows a health maintenance organization (HMO) to offer health insurance coverage for persons who reside outside of the HMO's geographic service area.

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

SECTION 1. 10-16-704 (1) (c) and (9) (a.7), Colorado Revised Statutes, are amended to read:

10-16-704. Network adequacy. (1) A carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health care services twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:

(c) Geographic accessibility, which in some circumstances may require the crossing of county OR STATE lines;

(9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204 (3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan. All rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract

provisions, regardless of whether or not such provisions are also specified in the access plan. The carrier shall prepare an access plan prior to offering a new managed care network and shall update an existing access plan whenever the carrier makes any material change to an existing managed care network, but not less than annually. The access plan of a carrier offering a managed care plan shall demonstrate the following:

(a.7) Geographic accessibility, which in some circumstances may require the crossing of county OR STATE lines; and

SECTION 2. Part 7 of article 16 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-704.5. Exception to network adequacy geographic requirements. (1) NOTWITHSTANDING ANY PROVISION OF THIS PART 7 TO THE CONTRARY, A HEALTH MAINTENANCE ORGANIZATION OFFERING HEALTH BENEFITS IN THIS STATE MAY OFFER HEALTH BENEFIT COVERAGE TO A SMALL EMPLOYER THAT DOES NOT RESIDE, OR WHOSE EMPLOYEES DO NOT RESIDE, WITHIN THE HEALTH MAINTENANCE ORGANIZATION'S GEOGRAPHIC SERVICE AREA REQUIRED BY SECTION 10-16-704.

(2) THE HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE A DISCLOSURE TO A SMALL EMPLOYER AND ITS EMPLOYEES WHO PURCHASE HEALTH INSURANCE COVERAGE UNDER THE CIRCUMSTANCE DESCRIBED IN SUBSECTION (1) OF THIS SECTION. SUCH DISCLOSURE SHALL BE GIVEN IN WRITING TO ALL INTERESTED POLICYHOLDERS AND CERTIFICATE HOLDERS AS PART OF THE SALES AND MARKETING MATERIALS BEFORE THE INSURER OR ENTITY APPROVES AN APPLICATION FOR INSURANCE FROM AN INSURED. THE DISCLOSURE SHALL CONTAIN THE FOLLOWING STATEMENT: "INTERESTED POLICYHOLDERS, CERTIFICATE HOLDERS, AND ENROLLEES ARE HEREBY GIVEN NOTICE THAT THIS SMALL GROUP POLICY REQUIRES THAT AN INSURED TRAVEL OUTSIDE OF THE GEOGRAPHIC AREA IN WHICH THE INSURED RESIDES, OR OUTSIDE OF THE GEOGRAPHIC AREA IN WHICH THE INSURED'S EMPLOYER RESIDES, TO RECEIVE COVERED HEALTH BENEFITS."

SECTION 3. 10-16-105 (7.6) (a) (I) and (7.6) (a) (II), Colorado Revised Statutes, are amended to read:

10-16-105. Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans. (7.6) (a) No small employer carrier is required to accept applications from or offer coverage pursuant to paragraph (a) of subsection (7.3) of this section:

(I) To a small employer, where the employer is not physically located

in the small employer carrier's established geographic service area, EXCEPT AS PROVIDED IN SECTION 10-16-704.5;

(II) To an employee, when the employee does not work or reside within the small employer carrier's established geographic area, EXCEPT AS PROVIDED IN SUBSECTION 10-16-704.5; or

SECTION 4. Effective date - applicability. (1) This act shall take effect January 1, 2003, unless a referendum petition is filed during the ninety-day period after final adjournment of the general assembly that is allowed for submitting a referendum petition pursuant to article V, section 1 (3) of the state constitution. If such a referendum petition is filed against this act or an item, section, or part of this act within such period, then the act, item, section, or part shall take effect on the specified date only if approved by the people.

(2) The provisions of this act shall apply to health benefit plans issued or renewed on or after the applicable effective date of this act.

DRAFT

Colorado Legislative Council Staff

NO FISCAL IMPACT

Drafting Number:	LLS 02-0127	**Date:**	November 9, 2001
Prime Sponsor(s):	Rep. Spradley Sen. Hagedorn	**Bill Status:**	Health Care Needs Task Force
		Fiscal Analyst:	Melodie Jones (303-866-4976)

TITLE: CONCERNING EXPANDED ACCESS TO HEALTH INSURANCE.

Summary of Assessment

This bill allows a health insurance carrier to cross state lines to comply with existing requirements for network adequacy. The bill allows a health maintenance organization (HMO) to offer health insurance coverage for persons who reside outside of the HMO's geographic service area provided that the HMO provides a disclosure to the small employer and its employees who purchase the health insurance coverage. The bill has an effective date of January 1, 2003.

The bill is assessed as having no state or local fiscal impact. The workload associated with making the necessary rules changes are minor and can be absorbed within the existing resources of the Division of Insurance, Department of Regulatory Agencies.

Departments Contacted

Regulatory Agencies