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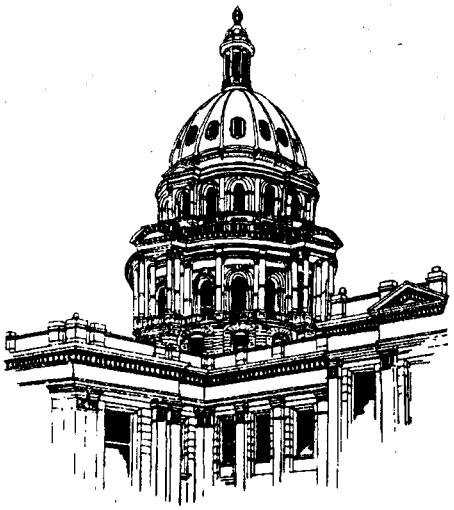
0506 Health Care Systems

Colorado Legislative Council

0506 Health Care Systems



Health Care Systems

Report to the

COLORADO

GENERAL ASSEMBLY

Colorado Legislative Council
Research Publication No. 506
November 2002

RECOMMENDATIONS FOR 2003

HEALTH CARE SYSTEMS COMMITTEE

Report to the
Colorado General Assembly

Research Publication No. 506
December 2002

COLORADO GENERAL ASSEMBLY

LEGISLATIVE COUNCIL

ROOM 029 STATE CAPITOL
DENVER, COLORADO 80203-1784
E-mail: lcs.ga@state.co.us
303-866-3521 FAX: 303-866-3855 TDD: 303-866-3472

December 2002

To Members of the Sixty-third General Assembly:

Submitted herewith is the final report of the Health Care Systems Committee. This committee was created pursuant to House Bill 02-1003. The purpose of the committee is to study current state health plans, analyze current health care statutes, study palliative care, and look at the extent to which provider networks may be coordinated to provide health benefit plans.

At its meeting on October 15, 2002, the Legislative Council reviewed the report of this committee. A motion to forward this report and the bills therein for consideration in the 2003 session was approved.

Respectfully submitted,

/s/ Representative Doug Dean
Chairman
Legislative Council

DD/JB/mm

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HEALTH CARE SYSTEMS COMMITTEE

Members of the Committee

Senator Bob Hagedorn
Co-Chairman
Senator Deanna Hanna
Senator Mark Hillman
Senator Dave Owens
Senator Stephanie Takis

Representative Lola Spradley
Co-Chairman
Representative Lauri Clapp
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Representative Lois Tocktrop
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Legislative Council Staff

Janis Baron
Principal Fiscal Analyst

Jeanette Chapman
Research Associate

Office of Legislative Legal Services

Julie Hoerner
Staff Attorney

Michele Hanigsberg
Staff Attorney

Executive Summary

Committee Charge

The Committee on Health Care Systems was created pursuant to House Bill 02-1003, concerning expanded access to health insurance and charged with studying the following issues regarding health care:

- which, if any, current state health plans or programs should be combined to create more efficient administration, expanded coverage, and cost savings to the state, including Medicaid, the Children's Basic Health Plan, and CoverColorado;
- how previous attempts to increase participation in the Children's Basic Health Plan have fallen short and what measures can be implemented to improve plan enrollment;
- an analysis of current health care statutes, health insurance statutes, any other possible barriers to the implementation of a state health plan, and an identification of what services are necessary;
- the issue of palliative care and whether such care is sufficiently available to Coloradans who need and desire it, plus any barriers to palliative care that can be addressed by the General Assembly;
- the extent to which provider networks can be coordinated through high deductible health benefits plans, supplemental policies, or hospital confinement indemnity plans; and
- the extent to which providers are able to offer discounts related to fee-for-service payment arrangements.

Committee Activities

The committee held a total of six meetings. The committee heard testimony from private insurers, hospitals, consumers, pharmaceutical companies, the National Conference of State Legislatures, the Department of Regulatory Agencies, and the Department of Health Care Policy and Financing. Topics of discussion included current trends in health care, availability of coverage, cost containment, and strategies that other states are trying to streamline and expand health care coverage for citizens.

The committee heard considerable testimony expressing concern about the cost of medical care. Several common themes emerged from these discussions including concern about the cost and size of state Medicaid programs and strategies for streamlining and

coordinating those programs, the cost of pharmaceuticals, the cost of hospital care, and the impact of mandates and technology on health care costs. The committee also discussed palliative care, ideas for increasing participation in the Children's Basic Health Plan, and federal Heath Insurance Flexibility and Accountability (HIFA) waivers.

Committee Recommendations

As a result of committee discussion and deliberation, the committee recommends seven bills for consideration in the 2003 legislative session.

Bill A — Prescription Medications Under the "Colorado Medical Assistance Act." Requires the Medical Services Board to promulgate rules to require that generic drugs be used when available for medication reimbursements under Medicaid.

Bill B — Care Management Pilot Program for the Oversight of Medical Services Provided to Specified Recipients of Medicaid. Requires the Department of Health Care Policy and Financing to develop and implement a care management pilot program to manage the medical services provided to fee-for-service and primary care physician program recipients under Medicaid.

Bill C — Limitation on Noneconomic Damages for Certain Physical Injuries in Medical Malpractice Actions. Clarifies limits on non-economic damage awards for medical malpractice. Includes physical impairment or disfigurement as non-economic damages.

Bill D — Implementation of the Federal "Employee Retirement Income Security Act" with Regard to the Administration of Requests for Health Benefits. Harmonizes provisions of Colorado law relating to the prompt payment of health benefits with the federal "Employee Retirement Income Security Act."

Bill E — Reimbursement to the Department of Health Care Policy and Financing for Medication that are Returned Under the "Colorado Medical Assistance Act." Directs the Department of Health Care Policy and Financing to develop and implement a drug utilization review process for Medicaid recipients receiving medical care from fee-for-service providers or through the primary care physician program.

Bill F — Prohibition of the Corporate Practice of Medicine by a Professional Services Corporation Formed by Persons Licensed to Practice Medicine. Clarifies that a professional services corporation formed by persons licensed to practice medicine may not engage in the corporate practice of medicine. Provides that a professional services corporation may not control the physician's independent professional judgment.

Bill G — Disclosure by a Health Care Provider to the Named Insured of the Estimated Charges for Nonemergency Procedures Prior to the Scheduling of Such Procedures. Requires health care providers to disclose the estimated cost of a procedure prior to the scheduling of a non-emergency procedure.

Statutory Authority and Responsibilities

Pursuant to House Bill 02-1003, the Interim Committee on Health Care Systems was charged with studying the following:

- which, if any, current state health plans or programs should be combined to create more efficient administration, expanded coverage, and costs savings to the state, including Medicaid, the Children's Basic Health Plan, and CoverColorado;

- how previous attempts to increase participation in the Children's Basic Health Plan have fallen short and what measures can be implemented to improve plan enrollment;

- an analysis of current health care statutes, health insurance statutes, any other possible barriers to the implementation of a state health plan, and an identification of what services are necessary;

- the issue of palliative care and whether such care is sufficiently available to Coloradans who need and desire it, plus any barriers to palliative care that can be addressed by the General Assembly;

- the extent to which provider networks can be coordinated through high deductible health benefits plans, supplemental policies, or hospital confinement indemnity plans; and

- the extent to which providers are able to offer discounts related to fee-for-service payment arrangements.

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 six meetings.

Committee Activities

Medicaid: coverage, services, expenditures

Of prime concern to the committee was the cost of and coverage provided by the state's Medicaid program. States have more flexibility, particularly through waivers, than ever before in organizing their Medicaid program, and that flexibility has allowed new strategies for conserving costs and expanding and improving care. The committee heard from the Department of Health Care Policy and Financing about the department's financial limitations and the different options it is pursuing to better serve Colorado's Medicaid recipients. The committee also looked at eligibility requirements, expenditures, enrollment processes, and costs for Medicaid, the Children's Basic Health Plan (CHIP), and CoverColorado in an effort to establish possible strategies for administrative streamlining.

The committee heard testimony about the impact of rising hospital costs on the costs of health care. Among the issues raised to address hospital costs were up-front disclosure of hospital costs to allow greater consumer choice as well as management strategies for decreasing paperwork and standardizing billing. Representatives of rural hospitals had an opportunity to discuss the challenges unique to small communities including difficulty finding job applicants, limited purchasing power, limited choice of insurers, and problems with Medicaid. They heard testimony from hospitals and insurers that hospitals have seen a significant rise in emergency room visits as people increasingly use emergency room visits for primary care, specialty care, and behavior health care.

Several states have taken advantage of new federal flexibility in designing and enhancing health care programs for the poor and uninsured through waivers such as the Health Insurance Flexibility and Accountability Initiative (HIFA). The initiative encourages states to use existing Medicaid or CHIP funds to provide health coverage to new populations of the uninsured, such as those at 200 percent of the federal poverty level.

Medical Savings Accounts/Multiple Employer Welfare Agreements

Alternatives to traditional insurance programs such as Medical Savings Accounts (MSAs) were among the ideas considered by the committee. The Independence Institute provided a presentation on MSAs, describing possible advantages to such accounts. MSAs allow individuals to invest their money in savings accounts and use the savings as necessary for a broad range of medical expenses including transportation and dental care. The committee expressed some doubt that MSAs could be a practical form of health insurance for most people. Federal laws limit qualifying coverage, contributions from employers and employees, as well as roll-over of funds.

Employers are finding it increasingly difficult to find and provide affordable health insurance for their employees. One strategy the committee heard about to alleviate this problem was Multiple Employer Welfare Associations (MEWAs) to allow small employers to pool with other small employers to purchase insurance. Health coverage under an MEWA is subject to state insurance law, including state laws covering small groups, if member employers have 50 or fewer employees.

Pharmaceuticals

In Colorado, approximately 90 percent of the state's Medicaid drug expenditures are for the elderly (35%) and the blind and disabled (54%). The two primary factors driving this growth are population increases in elderly, disabled and dually-eligible people and increases in drug use that are due to disease severity, disease prevalence, treatment intensity, and the availability of newer and multiple drugs. The increased use and cost of pharmaceuticals is frequently given as a reason for rising insurance costs. It is difficult, however, to show that pharmaceuticals can be directly linked to these cost increases. In some cases, effective use of pharmaceuticals has actually decreased the use of hospital and institutional care.

The committee heard discussion on the practicality of applying private sector cost saving strategies to Medicaid. Private sector insurers use prior authorization, prescription limits, therapeutic substitutions, and formularies and preferred drug lists in an effort to keep down costs. Colorado's Medicaid program currently pays for generic drugs in about 50 percent of prescriptions. If a generic is available, the state will not pay the full cost for the trade name drug.

In addition, the committee heard from a number of drug companies that have coordinated to provide a discount prescription drug service for the elderly who do not qualify for Medicaid; providing the drugs for a $12 to $15 copayment. Eligibility for this program, called Together Rx, is set at 200 percent of poverty and pharmaceutical companies have pledged to continue providing the program until Medicare includes a prescription drug benefit.

Disease Management

The Department of Health Care Policy and Financing has begun several disease management pilot programs for illnesses such as asthma and diabetes. The goals of the programs are to reduce avoidable health care utilizations, improve clients' self-care, improve the health and functional status of clients, and control costs. The programs provide phone calls, personal visits, written materials and videos as part of their interventions with patients' self-care. The department states that the programs will lead to cost savings within these client groups. In Denver, for example, one disease management program for diabetes patients saw a $660 cost decrease per client per year.

Palliative Care

Colorado has traditionally been a leader in providing hospice care. There are currently 37 hospice providers operating in the state. However, less than 10 percent of deaths in the state take place in hospice facilities. Of the deaths occuring in nursing facilities, about 25 percent of them received hospice care. Hospice care coverage under Medicaid has been limited to those with a prognosis of six months or less. The advent of new and better therapies has made identifying a patient's prognosis with any accuracy more difficult. The committee heard testimony indicating the need to widen the application of palliative care to hospitals and nursing homes, the need for Medicaid coverage of room and board in hospice facilities, and statewide education needs of medical professionals as well as the general public about palliative care.

Summary of Recommendations

As a result of the committee's activities, the following bills are recommended to the Colorado General Assembly.

Bill A — Concerning Prescription Medications Under the "Colorado Medical Assistance Act"

The bill stipulates that the Medical Services Board promulgate rules requiring that the generic equivalent of a brand-name drug be prescribed if it is a therapeutic equivalent. Allows for an exception when a patient has been stabilized on a brand-name drug. The Department of Health Care Policy and Financing is authorized to use savings in the medical services premiums appropriations to fund the review of exception requests. The bill also requires the Board to adopt rules allowing Medicaid recipients to receive their prescriptions by mail and requires the Department to develop and implement a drug utilization review process for fee-for-service and primary care physician programs. The department is authorized to use savings in the medical services premiums appropriations to fund this process.

Bill B — Concerning a Care Management Pilot Program for the Oversight of Medical Services Provided to Specified Recipients of Medicaid

The bill requires the Department of Health Care Policy and Financing to develop and implement a care management pilot program to manage medical services provided by the fee-for-service and primary care physician programs under Medicaid. The Department may limit the program geographically, determine eligibility, and selectively contract with providers. The Department is also authorized to use savings generated from the program to fund the pilot program. The Department is required to contract for an independent evaluation of the program examining participant outcomes, quality of care, and cost effectiveness.

Bill C — Concerning the Limitation on Noneconomic Damages for Certain Physical Injuries in Medical Malpractice Actions

The bill limits medical malpractice damage awards for non-economic loss or injury, including physical impairment or disfigurement, to a $250,000 cap.

Bill D — Concerning the Implementation of the Federal "Employee Retirement Income Security Act" with Regard to the Administration of Requests for Health Benefits

This bill updates Colorado law to reflect federal requirements in the "Employee Retirement Income Security Act" concerning procedures for denying health benefits. Specifically, the bill requires that urgent care determination for coverage be made within 72 hours of submission; preauthorization coverage determination be made within 15 days of submission; determinations that do not require preauthorization before treatment be made within 30 days; and disability benefits determination be made within 45 days.

The bill also includes specifications for extending the required time periods, circumstances in which a carrier may deny coverage, and information that must be included in a denial of health care coverage.

Bill E — Concerning Reimbursement to the Department of Health Care Policy and Financing for Medications That are Returned Under the "Colorado Medical Assistance Act"

Requires providers of pharmaceutical services to reimburse the Department of Health Care Policy and Financing for the cost of medictions that the Department has paid to the provider and that are returned.

Bill F — Concerning the Prohibition of the Corporate Practice of Medicine by a Professional Services Corporation Formed by Persons Licensed to Practice Medicine

The bill clarifies that a professional services corporation formed by persons licensed to practice medicine may not engage in the corporate practice of medicine and that a professional services corporation may not control the physician's independent professional judgement.

Bill G — Concerning Disclosure by a Health Care Provider to the Named Insured of the Estimated Charges for Nonemergency Procedures Prior to the Scheduling of Such Procedures

The bill requires health care providers to disclose the estimated costs to patients of a nonemergency procedure, prior to scheduling the procedure.

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/2002/02interim.

Meeting Summaries	Topics Discussed
August 12, 2002	Medicaid; Childrens Basic Health Plan.
August 26, 2002	Administrative streamlining: Medicaid, CHIP, and CoverColorado; HIFA and other waivers; The Oregon Health Plan.
August 27, 2002	Hospital costs; cost shifting; small group insurance; Multiple Employer Welfare Associations (MEWAs); Medical Savings Accounts (MSAs).
September 9, 2002	Prescription drugs under Medicaid; disease management; mandates; medical malpractice.
September 23, 2002	Palliative care; higher education - health care professionals; health care and technology; proposed legislation.
October 7, 2002	Committee discussion of proposed legislation.

Memoranda and Reports

State Budgets Under Stress: How Are States Planning to Reduce the Growth in Medicaid Costs?, The Kaiser Commission on Medicaid and the Uninsured, July 2002.

Why Are Premiums for Small Employer Health Insurance Going Up and What Can Policymakers Do About It?, Health Insurance Association of America Department of Policy and Information.

The Oregon Experience: Prioritizing Services and Expanding Coverage, Barbara Yondorf for the National Conference of State Legislatures, January, 2002.

Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns, Report to the Committee on Finance, U.S. Senate, United States General Accounting Office, July 2002.

"Decade After Health Care Crisis, Soaring Costs Bring New Strains," Robin Toner and Sheryl Gay Stolberg, The *New York Times*, August 10, 2002.

Dawn of a New Day: States Given More Flexibility in Crafting Medicaid Waivers, Laura Tobler, National Conference of State Legislatures, March 25, 2002.

Bill A

SENATE SPONSORSHIP

Hagedorn and Hanna

HOUSE SPONSORSHIP

Spradley, Jahn, and Tochtrop

A BILL FOR AN ACT

CONCERNING PRESCRIPTION MEDICATIONS UNDER THE "COLORADO MEDICAL ASSISTANCE ACT".

Bill Summary

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

Health Care Systems Interim Committee. Requires the medical services board to include in rules governing the reimbursement of medications under medicaid, the requirement that the generic equivalent of a brand-name drug be prescribed if the generic equivalent is a therapeutic equivalent to the brand-name drug. Allows for an exception to this requirement if the patient has been stabilized on a medication and a transition to the generic equivalent of the brand-name drug would be unacceptably disruptive. Authorizes the department of health care policy and financing ("department") to use savings in the medical services premiums appropriations to fund the administrative review of these exception requests.

Requires the medical services board to adopt by rule a system to allow medical assistance recipients to receive prescribed medications through mail order.

Requires the department to develop and implement a drug utilization review process for the fee-for-service and primary care physician programs. Authorizes the department to use savings in the medical services premiums appropriations to fund the development and implementation of this process.

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

SECTION 1. 26-4-406, Colorado Revised Statutes, is amended to read:

26-4-406. Providers - drug reimbursement. (1) As to drugs for which payment is made, the state ~~department's~~ BOARD'S rules ~~and regulations~~ for the payment therefor shall include ~~but need not be limited to the use of generic names on commonly used drugs~~ THE REQUIREMENT THAT THE GENERIC EQUIVALENT OF A BRAND-NAME DRUG BE PRESCRIBED IF THE GENERIC EQUIVALENT IS A THERAPEUTIC EQUIVALENT TO THE BRAND-NAME DRUG. THE STATE DEPARTMENT SHALL GRANT AN EXCEPTION TO THIS REQUIREMENT IF THE PATIENT HAS BEEN STABILIZED ON A MEDICATION AND THE TREATING PHYSICIAN, OR A PHARMACIST WITH THE CONCURRENCE OF THE TREATING PHYSICIAN, IS OF THE OPINION THAT A TRANSITION TO THE GENERIC EQUIVALENT OF THE BRAND-NAME DRUG WOULD BE UNACCEPTABLY DISRUPTIVE.

(2) IT IS THE GENERAL ASSEMBLY'S INTENT THAT REQUIRING THE USE OF A GENERIC EQUIVALENT OF A BRAND-NAME DRUG WILL PRODUCE SAVINGS WITHIN THE STATE'S MEDICAID PROGRAM. THE STATE DEPARTMENT, THEREFORE, IS AUTHORIZED TO USE SAVINGS IN THE MEDICAL SERVICES PREMIUMS APPROPRIATIONS TO FUND THE ADMINISTRATIVE REVIEW PROCESS REQUIRED BY SUBSECTION (1) OF THIS SECTION.

SECTION 2. Part 4 of article 4 of title 26, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-407.5. Prescribed drugs - mail order. (1) THE STATE BOARD SHALL ADOPT BY RULE A SYSTEM TO ALLOW MEDICAL ASSISTANCE RECIPIENTS TO RECEIVE PRESCRIBED MAINTENANCE MEDICATIONS THROUGH MAIL ORDER. THE STATE BOARD SHALL INCLUDE IN THE RULES THE DEFINITION OF MAINTENANCE MEDICATIONS. THE RULES MAY ALLOW FOR A MEDICAL ASSISTANCE RECIPIENT TO RECEIVE UP TO A SIX-MONTH SUPPLY, OR THE MAXIMUM ALLOWED UNDER FEDERAL LAW, OF MAINTENANCE MEDICATIONS USED TO TREAT CHRONIC MEDICAL CONDITIONS.

(2) THE STATE DEPARTMENT SHALL SEEK ANY FEDERAL AUTHORIZATION NECESSARY TO IMPLEMENT THIS SECTION.

SECTION 3. 26-4-408 (1), Colorado Revised Statutes, is amended, and the said 26-4-408 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

26-4-408. Prescribed drugs - utilization review. (1) The state department shall DEVELOP AND implement a drug utilization review process ~~using health care providers~~ to assure the appropriate utilization of drugs by patients ~~receiving~~ medical assistance ~~under this article~~ IN THE FEE-FOR-SERVICE AND PRIMARY CARE PHYSICIAN PROGRAMS. The review process shall include the monitoring of prescription information and shall address at a minimum underutilization and overutilization of benefit drugs. Periodic reports of findings and recommendations shall be forwarded to the state department.

(1.5) IT IS THE GENERAL ASSEMBLY'S INTENT THAT THE IMPLEMENTATION OF A DRUG UTILIZATION REVIEW PROCESS FOR THE FEE-FOR-SERVICE AND PRIMARY CARE PHYSICIAN PROGRAMS WILL PRODUCE SAVINGS WITHIN THE STATE'S MEDICAID PROGRAM. THE STATE DEPARTMENT, THEREFORE, IS AUTHORIZED TO USE SAVINGS IN THE MEDICAL SERVICES PREMIUMS APPROPRIATIONS TO FUND THE DEVELOPMENT AND IMPLEMENTATION OF A DRUG UTILIZATION REVIEW PROCESS FOR THESE PROGRAMS, AS REQUIRED BY SUBSECTION (1) OF THIS SECTION. ANY SAVINGS REALIZED IN EXCESS OF THE COST OF DEVELOPING AND IMPLEMENTING A DRUG UTILIZATION REVIEW PROCESS FOR THESE PROGRAMS SHALL REMAIN WITHIN THE MEDICAL SERVICES PREMIUMS APPROPRIATIONS TO PROVIDE MEDICAL SERVICES TO MEDICAL ASSISTANCE RECIPIENTS. THE STATE DEPARTMENT MAY CONTRACT ON A CONTINGENCY BASIS FOR THE DEVELOPMENT OR IMPLEMENTATION OF THE REVIEW PROCESS REQUIRED BY SUBSECTION (1) OF THIS SECTION.

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 03-0054	**Date:**	November 5, 2002
Prime Sponsor(s):	Sen. Hagedorn Rep. Spradley	**Bill Status:**	Health Care Systems Interim Committee
		Fiscal Analyst:	Janis Baron (303-866-3523)

TITLE: CONCERNING PRESCRIPTION MEDICATIONS UNDER THE "COLORADO MEDICAL ASSISTANCE ACT".

Fiscal Impact Summary	FY 2003/2004	FY 2004/2005
State Revenues General Fund	$ 0	$ 0
State Expenditures General Fund Federal Funds	($704,622) (415,571)	($574,816) (26,155)
FTE Position Change	0.8 FTE	1.0 FTE
Other State Impact: None		
Effective Date: Upon Signature of the Governor		
Appropriation Summary for FY 2003/2004: The Department of Health Care Policy and Financing (DHCPF) will require an appropriation which adjusts multiple line items in the department's total budget for FY 2003-04 and authorizes 0.8 new FTE. See the State Appropriations section of this fiscal note for details (p. 3).		
Local Government Impact: None		

Summary of Legislation

The bill includes the following provisions regarding prescription medications in the state's Medicaid program:

- requires a generic drug equivalent of a brand-name drug to be prescribed if the generic drug is a therapeutic equivalent to the brand-name drug;

- makes an exception to the above requirement if the patient is stabilized on a medication and the treating physician deems that a transition to a generic drug would be unacceptably disruptive;

- requires the state Medical Services Board to adopt by rule a mail order pharmacy benefit for Medicaid clients on maintenance drugs;

- requires the DHCPF to develop and implement a drug utilization review process for the fee-for-service and primary care physician programs;

- authorizes the DHCPF to use savings in its medical services premiums appropriations to fund administrative review of generic drugs vs. brand-name drugs and to fund drug utilization review in the fee-for-service and primary care physician programs; and

- stipulates that any savings realized in excess of the cost to develop and implement a drug utilization review process shall remain within the medical services premiums appropriations.

State Expenditures

It is estimated that the bill will result in a net savings of $1,120,193 in FY 2003-04 and $600,971 in FY 2004-05 in the DHCPF. Additionally, the department will require 0.8 FTE in FY 2003-04 annualized to 1.0 FTE in FY 2004-05. Costs will be incurred to develop and implement the three programs/processes required in the bill and all three will result in savings in the medical services premiums appropriations once implemented. The bill stipulates that only those savings realized for the drug utilization review process will remain in the medical services premiums appropriations. Thus, savings associated with the use of generic drugs and mail order prescriptions are noted as reduced expenditures in the medical services premiums appropriations. Savings will begin January 1, 2004. One year of explicit savings will be realized, half in FY 2003-04 and half in FY 2004-05. Beginning with FY 2005-06, savings will be absorbed into the base medical services premiums calculations. Listed below are the primary assumptions and facts used in determining the bill's fiscal impact.

Section 26-4-406 — Generic Drugs Mandate

- ➔ Data Source - 2002 Executive Summary Report 3710-001 used to identify brand name drugs with a generic equivalent.
- ➔ Total monthly brand name prescriptions is 18,097. Of these, 50% will go generic (9,049), or 108,588 prescriptions annually.
- ➔ Average savings estimated at $20.25 per prescription.
- ➔ Pharmacist III position is needed to meet all of the bill's requirements: review exceptions requests to the generic drugs mandate; oversee the mail order pharmacy program; and write and monitor the drug utilization review contract.

Section 26-4-407.5 — Mail Order Pharmacy for Maintenance Drugs

- ➔ DHCPF will contract with out-of-state mail order pharmacies; Colorado has no mail-in providers; benefit will be limited to a 3-month supply.
- ➔ Maintenance drug list is First Data Source.
- ➔ Reimbursement rate will be the average wholesale price (AWP) minus 15% for generic drugs, AWP minus 50% for brand-name drugs, and include a $4.00 dispensing fee.
- ➔ Due to annual eligibility redetermination requirements, only those Medicaid clients in the OAP-A, OAP-B, and AND/AB eligibility categories will qualify for the program (assume 50% of eligibles will participate).
- ➔ Nursing facility clients are exempt from the program.
- ➔ No co-pay will be required for drugs filled in the program.
- ➔ Savings are estimated at 16%, based on the the savings PERA identifies for its mail order pharmacy benefit.
- ➔ Two-thirds of the current cost of total dispensing fees will be saved because prescription is filled once every 3 months.
- ➔ Currently, 20% of maintenance drugs for the program's eligible participants are filled at under 1 month's supply or over 90 days. Thus, no savings on this portion.

Section 26-4-408 — Drug Utilization Review

- ➔ Savings generated by a drug utilization review contract will be approximately 1% of total drug expenditures.
- ➔ DHCPF will use a fixed-fee contract rather than a contingency fee contract to qualify for federal funds at 75% of the contract's total cost.

The table on page 4 lists the program costs and savings according to bill section. Marginal variances in funding splits are due to rounding. Detailed worksheets are available in the Legislative Council, Fiscal Note Office.

State Appropriations

The fiscal note indicates that the Department of Health Care Policy and Financing should receive the following appropriation adjustments to its section in the FY 2003-04 Long Bill.

- ➔ Medical Programs Administration: $881,807 Total and 0.8 FTE
  $220,452 General Fund and $661,355 federal funds
- ➔ Medicaid Management Information System Contract: ($3,706) Total
  ($926) General Fund and ($2,779) federal funds
- ➔ Medical Services Premiums: ($1,120,193) Total
  ($704,622) General Fund and ($415,571) federal funds

Table 1: Total Costs and Savings Under Bill		
Cost Components per Bill Section	**FY 2003-04**	**FY 2004-05**
Section 26-4-406 — Generic Drugs Mandate		
Pharmacist III (0.8 FTE year one and 1.0 FTE year two)	$ 60,585	$ 71,084
Prior Authorization Reviews	521,222	1 042,445
Medical Services Premiums	(1,099,454)	(1,099,454)
Subtotal - Savings Revert	(517,646)	14,075
General Fund	(404,275)	(271,345)
Federal Funds	(113,371)	285,420
Section 26-4-407.5 — Mail Order Prescriptions		
Medicaid Management Information System (MMIS) -		
Systems changes @ $125/hour for 100 hours	$ 12,500	$ 0
MMIS - Claims Reduction Due to 3-Month Fillings	(16,206)	(16,206)
Dispensing Fee Savings	(102,608)	(102,608)
Medical Services Premiums	(496,232)	(496,232)
Subtotal - Savings Revert	(602,546)	(615,046)
General Fund	(300,347)	(303,472)
Federal Funds	(415,571)	(311,575)
Section 26-4-408 — Drug Utilization Review		
Fixed Fee Contract (1% of total drug expenditures)	$ 300,000	$ 600,000
Medical Services Premiums	(1,345,328)	(2,873,620)
Subtotal - Savings Remain in Medical Services Premiums	(1,045,328)	(2,273,620)
General Fund	(597,664)	(1,286,810)
Federal Funds	(447,664)	(986,810)
BILL TOTAL - NET	($ 1,120,193)	($ 600,971)
General Fund	(704,622)	(574,816)
Federal Funds	(415,571)	(26,155)
FTE	0.8 FTE	1.0 FTE

Departments Contacted

Health Care Policy and Financing

Bill B

SENATE SPONSORSHIP

Owen

HOUSE SPONSORSHIP

Tochtrop

A BILL FOR AN ACT

CONCERNING A CARE MANAGEMENT PILOT PROGRAM FOR THE OVERSIGHT OF MEDICAL SERVICES PROVIDED TO SPECIFIED RECIPIENTS OF MEDICAID.

Bill Summary

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

Health Care Systems Interim Committee. Requires the department of health care policy and financing ("department") to develop and implement a care management pilot program ("program") for the purpose of managing the medical services provided to fee-for-service and primary care physician program recipients under the medicaid program.

Authorizes the department to limit the program geographically, determine who is eligible to participate in the program, and utilize selective contracting when choosing the providers that will participate in the program, as long as the department ensures reasonable access to medically necessary services. Allows the department flexibility in determining the reimbursement for acute care providers, long-term care community providers, and class I nursing facilities when it is necessary to serve a program participant in a more medically appropriate and cost-effective setting.

Authorizes the department to use savings generated from managing the care provided to program recipients in the medical services premiums appropriations to fund the program. Requires the department to contract for an independent evaluation of the program, which shall include an evaluation of program participant outcomes, the quality of care that was received by the program participants, and the cost effectiveness of the program.

Sunsets the program, effective July 1, 2009.

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

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

(a) Currently, the services provided under Colorado's medicaid fee-for-service and primary care physician programs are unmanaged;

(b) The medicaid long-term care system, with the exception of the Program for All-Inclusive Care for the Elderly, is an unmanaged fee-for-services system;

(c) The current long-term care system lacks appropriate incentives for efficiency, quality, and value in the delivery of services to eligible clients;

(d) Management of long-term and acute care will improve the provision of services, encourage the development of innovative models of care, and will enhance accountability, ensuring that state dollars are used more effectively;

(e) It is essential that the state develop a cost-effective approach to managing the care provided through these programs to ensure the sustainability of the system of care provided under medicaid.

(2) The general assembly, therefore, declares that it is necessary to authorize the department of health care policy and financing to contract for the

management of care provided under the fee-for-service and primary care physician programs.

SECTION 2. Part 4 of article 4 of title 26, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-424. Care management pilot program - fee-for-service and primary care physician program recipients - selective contracting - independent evaluation - repeal. (1) (a) THE STATE DEPARTMENT SHALL DEVELOP AND IMPLEMENT A CARE MANAGEMENT PILOT PROGRAM, REFERRED TO IN THIS SECTION AS THE "PILOT PROGRAM", FOR THE PURPOSE OF MANAGING THE MEDICAL SERVICES PROVIDED TO FEE-FOR-SERVICE AND PRIMARY CARE PHYSICIAN PROGRAM RECIPIENTS. THE PILOT PROGRAM SHALL BE DESIGNED TO MONITOR THE CONTINUUM OF CARE PROVIDED TO EACH PARTICIPATING RECIPIENT, WHICH SHALL INCLUDE MANAGEMENT OF A PARTICIPANT'S CARE IN ALL CARE SETTINGS INCLUDING INPATIENT HOSPITALIZATION.

(b) IT IS THE GENERAL ASSEMBLY'S INTENT THAT MANAGING THE CARE PROVIDED TO FEE-FOR-SERVICE AND PRIMARY CARE PHYSICIAN PROGRAM RECIPIENTS WILL BE COST-EFFECTIVE FOR THE STATE'S MEDICAID PROGRAM. THE STATE DEPARTMENT, THEREFORE, IS AUTHORIZED TO USE SAVINGS IN THE MEDICAL SERVICES PREMIUMS APPROPRIATIONS TO FUND THE PILOT PROGRAM AUTHORIZED IN THIS SECTION. THE STATE DEPARTMENT MAY CONTRACT ON A CONTINGENCY BASIS FOR THE DEVELOPMENT OR IMPLEMENTATION OF THE PILOT PROGRAM.

(2) (a) THE STATE DEPARTMENT IS AUTHORIZED TO LIMIT THE PILOT PROGRAM GEOGRAPHICALLY AND SHALL DETERMINE WHO IS ELIGIBLE TO PARTICIPATE IN THE PILOT PROGRAM. THE STATE DEPARTMENT MAY USE SELECTIVE CONTRACTING WHEN CHOOSING THE PROVIDERS THAT WILL PARTICIPATE IN THE PILOT PROGRAM, BUT SHALL ENSURE REASONABLE ACCESS TO MEDICALLY NECESSARY SERVICES.

(b) NOTWITHSTANDING ANY PROVISION IN THIS ARTICLE TO THE CONTRARY, THE STATE DEPARTMENT SHALL HAVE FLEXIBILITY IN DETERMINING THE REIMBURSEMENT FOR ACUTE CARE PROVIDERS, LONG-TERM CARE COMMUNITY PROVIDERS, AND CLASS I NURSING FACILITIES WHEN IT IS NECESSARY TO SERVE A PILOT PROGRAM PARTICIPANT IN A MORE MEDICALLY APPROPRIATE AND COST-EFFECTIVE SETTING.

(3) THE STATE DEPARTMENT SHALL SEEK ANY NECESSARY FEDERAL AUTHORIZATION FOR THE PURPOSES OF IMPLEMENTING THE CARE MANAGEMENT PILOT PROGRAM.

(4) THE STATE DEPARTMENT SHALL CONTRACT FOR AN INDEPENDENT EVALUATION OF THE PILOT PROGRAM, WHICH SHALL INCLUDE AN EVALUATION OF PILOT PROGRAM PARTICIPANT OUTCOMES, THE QUALITY OF CARE THAT WAS RECEIVED BY THE PARTICIPANTS IN THE PILOT PROGRAM, AND THE COST EFFECTIVENESS OF THE PILOT PROGRAM. THE EVALUATION SHALL BE SUBMITTED TO THE HEALTH, ENVIRONMENT, CHILDREN AND FAMILIES COMMITTEE OF THE SENATE AND THE HEALTH, ENVIRONMENT, WELFARE, AND

INSTITUTIONS COMMITTEE OF THE HOUSE OF REPRESENTATIVES ON OR BEFORE JANUARY 1, 2009.

(5) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2009. PRIOR TO SUCH REPEAL, THE CARE MANAGEMENT PILOT PROGRAM IMPLEMENTED BY THE STATE DEPARTMENT PURSUANT TO THIS SECTION SHALL BE REVIEWED AS PROVIDED FOR IN SECTION 24-34-104, C.R.S.

SECTION 3. 24-34-104 (40), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

24-34-104. General assembly review of regulatory agencies and functions for termination, continuation, or reestablishment. (40) The following agencies, functions, or both, shall terminate on July 1, 2009:

(j) THE CARE MANAGEMENT PILOT PROGRAM IMPLEMENTED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING PURSUANT TO SECTION 26-4-424, C.R.S.

SECTION 4. Effective date. This act shall take effect July 1, 2003.

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

Colorado Legislative Council Staff

STATE FISCAL IMPACT

Drafting Number:	LLS 03-0085	**Date:**	December 5, 2002
Prime Sponsor(s):	Sen. Owen Rep. Tochtrop	**Bill Status:**	Health Care Systems Interim Committee
		Fiscal Analyst:	Janis Baron (303-866-3523)

TITLE: CONCERNING A CARE MANAGEMENT PILOT PROGRAM FOR THE OVERSIGHT OF MEDICAL SERVICES PROVIDED TO SPECIFIED RECIPIENTS OF MEDICAID.

Fiscal Impact Summary	FY 2003/2004	FY 2004/2005
State Revenues General Fund		
State Expenditures General Fund Federal Fund	 ($ 32,390) 31,610	 ($ 2,272,006) (2,195,256)
FTE Position Change	1.6 FTE	2.0 FTE
Other State Impact: None		
Effective Date: July 1, 2003		
Appropriation Summary for FY 2003/2004: The Department of Health Care Policy and Financing (DHCPF) will require an appropriation which adjusts multiple line items in the department's total budget for FY 2003-04 and authorizes 1.6 new FTE. See the State Appropriations section of this fiscal note for a summary of required appropriations.		
Local Government Impact: None		

Summary of Legislation

The bill requires the Department of Health Care Policy and Financing (DHCPF) to develop and implement a Care Management Pilot Program (CMPP) to manage the medical services provided fee-for-service and primary care physician program recipients. The pilot program is required to manage all aspects of a recipient's care, including inpatient hospitalization. The bill deems the pilot program to be cost-effective and authorizes savings in the medical services premiums appropriations to fund its development. The DHCPF is authorized to: (1) limit the pilot program geographically; (2) determine eligibility for program participation; and (3) determine reimbursement to providers. The DHCPF is required to contract for an independent evaluation of the pilot program to be submitted on or before January 1, 2009, to the General Assembly. The pilot program is repealed July 1, 2009.

State Expenditures

The bill results in both costs and savings in the DHCPF to implement the pilot program with net General Fund and federal funds savings in both fiscal years. Total costs are estimated at $3,208,019 in FY 2003-04 and $11,957,734 in FY 2004-05; total savings are estimated at $3,208,800 in year one and $16,424,997 in year two. Table 1 below identifies the costs and savings incurred under the bill.

TABLE 1: COSTS/SAVINGS FOR CARE MANAGEMENT PILOT PROGRAM		
COSTS	**FY 2003-04**	**FY 2004-05**
MEDICAL PROGRAMS ADMINISTRATION		
Personal Services and Operating Expenses	$ 101,584 1.6 FTE	$ 119,500 2.0 FTE
Medicaid Management Information System (total of 2,252 hours @ $125/hour)	128,000	153,500
Contractual Services — Pilot program design consultation	6,250	18,750
SUBTOTAL: ADMINISTRATION COSTS	**$ 235,834**	**$ 291,750**
MEDICAL SERVICES PREMIUMS		
Contractual Services — Long-term Care Management Pilot Program Feasibility Study	250,000	0
Long-term Care Management Pilot Program — Care Coordination Contractor	0	1,064,810
Physician Incentive Program — Incentive Payments	430,185	860,369
Care Management — Vendor Contracts	2,292,000	9,740,805
SUBTOTAL: MEDICAL SERVICES PREMIUMS COSTS	**$ 2,972,185**	**$ 11,665,984**
TOTAL COSTS	**$ 3,208,019**	**$ 11,957,734**
SAVINGS — MEDICAL SERVICES PREMIUMS (only)		
Care Management Pilot Program	($ 3,208,800)	($ 13,637,127)
Long-term Care Management Pilot Program	0	(2,787,870)
TOTAL: MEDICAL SERVICES PREMIUMS SAVINGS	**($ 3,208,800)**	**($16,424,997)**
BILL NET TOTAL **General Fund** **Federal Funds**	**($ 781)** **(32,390)** **31,610**	**($ 4,467,263)** **(2,272,006)** **(2,195,256)**

Background. The DHCPF utilizes a number of procedures/programs to provide care management oversight for the clients it serves. These include utilization review of long-term care and acute care services, quality assurance of all health programs, a 24-hour seven days per week Medicaid client telephone service operated by registered nurse case managers, the Primary Care Physician Program (PCPP), the Demonstration Care Management and Organization Pilot (DCMOP), and the Long-term Care Program.

The DCMOP, initiated in July 2002, is privately funded through pharmaceutical companies and provides care management services to high risk, fee-for-service targeted Medicaid populations in 14 Colorado counties. The DCMOP will run through December 2004 and will serve clients with schizophrenia, asthma, diabetes, heart disease, pulmonary diseases, and high-risk neonates. A comparison of pre-pilot costs with post-intervention costs will determine the cost effectiveness of the individual pilots. **The department will use the outcome data of the DCMOP to expand the demonstration pilot throughout the state pursuant to this bill.**

The primary assumptions used in determining the bill's fiscal impact are noted below. Detailed worksheets are available in the Legislative Council, Fiscal Note Office.

- → The CMPP will begin January 2004.
- → The CMPP will be a voluntary enrollment program with a client caseload estimated at 4,450 in FY 2003-04 and 15,804 in FY 2004-05.
- → The department will require 1.0 FTE General Professional IV and 1.0 FTE Statistical Analyst III to monitor, track, and provide all the analysis requirements of the CMPP. Both positions will be required September 2003 (1.6 FTE in year one annualized to 2.0 FTE in year two).
- → The department will select a fixed amount vendor vs. a contingency based contract for the CMPP. DHCPF research indicates that contingency contracts are less cost effective when operating a "targeted vs. a population based" program. Vendor contracts for actual care management services are estimated at $2.3 million in FY 2003-04 and $9.7 million in FY 2004-05.
- → DHCPF research estimates a two-to-one return on investment for all care coordination/management interventions. Annual savings for the pilots are **estimated** at 140 percent of the average annual cost per client for the population in each care coordination/care management category, or $3.2 million in FY 2003-04 and $13.6 million in FY 2004-05. **Projected savings may be modified once greater data becomes available from the DCMOP.**
- → The addition of incentive payments to physicians in the PCPP program will save health care dollars (estimated at $4.145 per member month). These costs are estimated at $0.4 million in FY 2003-04 and $0.9 million in FY 2004-05.

- → The DHCPF will contract for a feasibility study, cost assessment and planning process for a Long-term Care Management Pilot in FY 2003-04 at a total cost of $250,000.
- → A Long-term Care Management Pilot will begin January 2005 at an estimated cost of $1.1 million in FY 2004-05. Of the total, $0.5 million is network management services and $0.6 is the care coordination contractor. Costs for FY 2005-06 (full-year implementation) are estimated at $2.5 million.
- → Savings in the Long-term Care Management Pilot are based upon a 2.5 percent decrease in total nursing facility usage in the Denver metropolitan area with those savings redistributed to Home- and Community-Based Services for the Elderly, Blind and Disabled; $2.8 million in FY 2004-05 and $9.5 million in FY 2005-06.
- → The DHCPF will require an estimated $500,000 to contract for an independent evaluation of the pilot program, due January 1, 2009. The cost for such an evaluation will be incurred no sooner than FY 2005-06.

State Appropriations

- → Medicaid Management Information System — $128,000, of which $32,000 is General Fund and $96,000 is federal funds.
- → Medical Programs Administration — $107,834, of which $53,917 is General Fund and $53,917 is federal funds
- → Net Medical Services Premiums — ($781), of which ($32,390) is General Fund savings and $31,610 is federal funds

Departments Contacted

Health Care Policy and Financing Regulatory Agencies

Bill C

SENATE SPONSORSHIP

Hillman

HOUSE SPONSORSHIP

Williams T. and Clapp

A BILL FOR AN ACT

CONCERNING THE LIMITATION ON NONECONOMIC DAMAGES FOR CERTAIN PHYSICAL INJURIES 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.)

Health Care Systems Interim Committee. Clarifies that damages awarded for noneconomic loss or injury in a medical malpractice action shall be subject to the $250,000 noneconomic loss cap. Includes physical impairment or disfigurement claims in medical malpractice actions as noneconomic loss or damage claims subject to the $250,000 noneconomic loss cap.

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

SECTION 1. 13-21-102.5 (3) (a), Colorado Revised Statutes, is amended to read:

13-21-102.5. Limitations on damages for noneconomic loss or injury. (3) (a) In any civil action OTHER THAN MEDICAL MALPRACTICE ACTIONS in which damages for noneconomic loss or injury may be awarded, the total of such damages shall not exceed the sum of two hundred fifty thousand dollars, unless the court finds justification by clear and convincing evidence therefor. In no case shall the amount of ~~such~~ NONECONOMIC LOSS OR INJURY damages exceed five hundred thousand dollars. THE DAMAGES FOR NONECONOMIC LOSS OR INJURY IN A MEDICAL MALPRACTICE ACTION SHALL NOT EXCEED THE LIMITATIONS ON NONECONOMIC LOSS OR INJURY SPECIFIED IN SECTION 13-64-302.

SECTION 2. 13-21-203 (1), Colorado Revised Statutes, is amended to read:

13-21-203. Limitation on damages. (1) (a) All damages accruing under section 13-21-202 shall be sued for and recovered by the same parties and in the same manner as provided in section 13-21-201, and in every such action the jury may give such damages as they may deem fair and just, with reference to the necessary injury resulting from such death, including damages for noneconomic loss or injury as defined in section 13-21-102.5 and subject to the limitations of this section and including within noneconomic loss or injury damages for grief, loss of companionship, pain and suffering, and emotional stress, to the surviving parties who may be entitled to sue; and also having regard to the mitigating or aggravating circumstances attending any such wrongful act, neglect, or default; except that, if the decedent left neither a

widow, a widower, minor children, nor a dependent father or mother, the damages recoverable in any such action shall not exceed the limitations for noneconomic loss or injury set forth in section 13-21-102.5, unless the wrongful act, neglect, or default causing death constitutes a felonious killing, as defined in section 15-11-803 (1) (b), C.R.S., and as determined in the manner described in section 15-11-803 (7), C.R.S., in which case there shall be no limitation on the damages for noneconomic loss or injury recoverable in such action. No action shall be brought and no recovery shall be had under both section 13-21-201 and section 13-21-202, and in all cases the plaintiff is required to elect under which section he or she will proceed. There shall be only one civil action under this part 2 for recovery of damages for the wrongful death of any one decedent. Notwithstanding anything in this section or in section 13-21-102.5 to the contrary, there shall be no recovery under this part 2 for noneconomic loss or injury in excess of two hundred fifty thousand dollars, unless the wrongful act, neglect, or default causing death constitutes a felonious killing, as defined in section 15-11-803 (1) (b), C.R.S., and as determined in the manner described in section 15-11-803 (7), C.R.S.

(b) THE DAMAGES RECOVERABLE FOR NONECONOMIC LOSS OR INJURY IN ANY MEDICAL MALPRACTICE ACTION SHALL NOT EXCEED THE LIMITATIONS ON NONECONOMIC LOSS OR INJURY SET FORTH IN SECTION 13-64-302.

SECTION 3. 13-64-302 (1), Colorado Revised Statutes, is amended to read:

13-64-302. Limitation of liability - interest on damages. (1) (a) AS USED IN THIS SECTION:

(I) "DERIVATIVE NONECONOMIC LOSS OR INJURY" MEANS NONECONOMIC LOSS OR INJURY TO PERSONS OTHER THAN THE PERSON SUFFERING THE DIRECT OR PRIMARY LOSS OR INJURY.

(II) "NONECONOMIC LOSS OR INJURY" MEANS NONPECUNIARY HARM FOR WHICH DAMAGES ARE RECOVERABLE BY THE PERSON SUFFERING THE DIRECT OR PRIMARY LOSS OR INJURY, INCLUDING PAIN AND SUFFERING, INCONVENIENCE, EMOTIONAL STRESS, PHYSICAL IMPAIRMENT OR DISFIGUREMENT, AND IMPAIRMENT OF THE QUALITY OF LIFE. "NONECONOMIC LOSS OR INJURY" DOES NOT INCLUDE PUNITIVE OR EXEMPLARY DAMAGES.

(b) The total amount recoverable for all damages for a course of care for all defendants in any civil action for damages in tort brought against a health care professional, as defined in section 13-64-202, or a health care institution, as defined in section 13-64-202, or as a result of binding arbitration, whether past damages, future damages, or a combination of both, shall not exceed one million dollars, present value per patient, including any ~~derivative~~ claim FOR DERIVATIVE NONECONOMIC LOSS OR INJURY by any other claimant, of which not more than two hundred fifty thousand dollars, present value per patient, including any derivative claim by any other claimant, shall be

attributable to noneconomic loss or injury, ~~as defined in section 13-21-102.5 (2) (a) and (2) (b),~~ whether past damages, future damages, or a combination of both; except that if, upon good cause shown, the court determines that the present value of the amount of lost past earnings and the present value of lost future earnings, or the present value of the amount of past medical and other health care costs and the present value of the amount of future medical and other health care costs, or both, when added to the present value of other past damages and the present value of other future damages, would exceed such limitation and that the application of such limitation would be unfair, the court may award the present value of additional future damages only for loss of such excess future earnings, or such excess future medical and other health care costs, or both. The limitations of this section are not applicable to a health care professional who is a public employee under the "Colorado Governmental Immunity Act" and are not applicable to a certified health care institution which is a public entity under the "Colorado Governmental Immunity Act". For purposes of this section, "present value" has the same meaning as that set forth in section 13-64-202 (7). The existence of the limitations and exceptions thereto provided in this section shall not be disclosed to a jury.

SECTION 4. Effective date - applicability. This act shall take effect July 1, 2003, and shall apply to acts or omissions occurring on or after said date.

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

DRAFT

Colorado Legislative Council Staff

NO FISCAL IMPACT

Drafting Number:	LLS 03-0209	**Date:**	November 4, 2002
Prime Sponsor(s):	Rep. Williams T. Sen. Hillman	**Bill Status:**	Health Care Systems Interim Committee
		Fiscal Analyst:	Janis Baron (303-866-3523)

TITLE: CONCERNING THE LIMITATION ON NONECONOMIC DAMAGES FOR CERTAIN PHYSICAL INJURIES IN MEDICAL MALPRACTICE ACTIONS.

Summary of Assessment

The bill clarifies that damages awarded for noneconomic loss or injury in a medical malpractice action shall be subject to the $250,000 noneconomic loss cap. The bill defines "derivative noneconomic loss or injury" and "noneconomic loss or injury" for the purposes of Section 13-64-302, C.R.S.

The bill is assessed at having no state or local fiscal impact. The bill includes an effective date of July 1, 2003, and applies to acts or omissions occurring on or after that date.

Departments Contacted

Judicial

Bill D

SENATE SPONSORSHIP

Hagedorn

HOUSE SPONSORSHIP

Spradley, Jahn, and Tochtrop

A BILL FOR AN ACT

CONCERNING THE IMPLEMENTATION OF THE FEDERAL "EMPLOYEE RETIREMENT INCOME SECURITY ACT" WITH REGARD TO THE ADMINISTRATION OF REQUESTS FOR HEALTH BENEFITS.

Bill Summary

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

Health Care Systems Interim Committee. Harmonizes provisions of law concerning the procedure for denying health benefits with the federal "Employee Retirement Income Security Act" (ERISA). Specifically, requires that:

- Urgent care determination for coverage be made not later than 72 hours after submission;
- Determinations for preauthorization coverage be made not later than 15 days after submission;
- Determinations that do not require preauthorization before treatment be made within 30 days; and
- Determinations for disability benefits be made within 45 days.

Specifies instances when time frames may be extended for additional information. Clarifies when time periods are tolled. Clarifies that a carrier may deny coverage because of eligibility in the health benefit plan, the application of utilization review, and determinations of a benefit or service as experimental or investigational.

Outlines the specific information that must be included in a denial of health benefit coverage. Clarifies the qualifications of a health care provider who may review denial of health benefit coverage. Requires that a covered person be notified of the provider's failure to follow the proper request submission processes.

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

SECTION 1. 10-16-113 (1), (3) (a), and (3) (b) (II), Colorado Revised Statutes, are amended, and the said 10-16-113 is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

10-16-113. Procedure for denial of benefits. (1) (a) A health ~~coverage~~ BENEFIT plan ~~shall not~~ MAY ONLY make a determination, IN WHOLE OR IN PART, that it will deny a request for reimbursement for or coverage of medical treatment or other benefits for a covered individual on the grounds that such treatment or covered benefit is: ~~not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.~~

(I) NOT A COVERED BENEFIT;

(II) NOT A COVERED BENEFIT THROUGH THE APPLICATION OF UTILIZATION REVIEW; OR

(III) DETERMINED TO BE EXPERIMENTAL OR INVESTIGATIONAL OR NOT MEDICALLY NECESSARY OR APPROPRIATE.

(b) A DENIAL OF A COVERED BENEFIT SHALL BE MADE PURSUANT TO THE PROVISIONS OF THIS SECTION.

(c) FOR THE PURPOSES OF THIS SECTION, A DENIAL OF A PREAUTHORIZATION FOR TREATMENT OR SERVICES SHALL BE CONSIDERED A DENIAL OF A COVERED BENEFIT AND SHALL BE MADE PURSUANT TO THE PROVISIONS OF THIS SECTION.

(3) (a) (I) All denials of requests for reimbursement for medical treatment, standing referrals, or other benefits on the grounds that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient shall include:

(A) An explanation of the specific medical basis for the denial; ~~and shall advise the covered person of the right to appeal such decision.~~

(B) THE SPECIFIC REASONS FOR THE ADVERSE DETERMINATION;

(C) REFERENCE TO THE SPECIFIC HEALTH COVERAGE PLAN PROVISIONS ON WHICH THE DETERMINATION IS BASED;

(D) A DESCRIPTION OF THE HEALTH COVERAGE PLAN'S REVIEW PROCEDURES AND THE TIME LIMITS APPLICABLE TO SUCH PROCEDURES AND SHALL ADVISE THE COVERED PERSON OF THE RIGHT TO APPEAL SUCH DECISION; AND

(E) A DESCRIPTION OF ANY ADDITIONAL MATERIAL OR INFORMATION NECESSARY ~~FOR~~ THE COVERED PERSON TO PERFECT THE REQUEST FOR BENEFITS AND AN EXPLANATION OF WHY SUCH MATERIAL OR INFORMATION IS NECESSARY.

(II) IN THE CASE OF AN ADVERSE BENEFIT DETERMINATION BY A GROUP HEALTH BENEFIT PLAN OR A PLAN PROVIDING DISABILITY BENEFITS:

(A) IF AN INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION WAS RELIED UPON IN MAKING THE ADVERSE DETERMINATION, THE CARRIER SHALL FURNISH THE POLICYHOLDER OR INSURED WITH EITHER THE SPECIFIC RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION OR A STATEMENT THAT SUCH RULE, GUIDELINE, PROTOCOL, OR OTHER CRITERION WAS RELIED UPON IN MAKING THE ADVERSE DETERMINATION AND THAT A COPY OF SUCH RULE, GUIDELINE, PROTOCOL, OR OTHER CRITERION WILL BE PROVIDED FREE OF CHARGE TO THE COVERED PERSON UPON REQUEST; OR

(B) IF THE ADVERSE BENEFIT DETERMINATION IS BASED ON A MEDICAL NECESSITY OR EXPERIMENTAL TREATMENT OR SIMILAR EXCLUSION OR LIMIT, THE CARRIER SHALL FURNISH THE POLICYHOLDER OR INSURED WITH EITHER AN EXPLANATION OF THE SCIENTIFIC OR CLINICAL JUDGMENT FOR THE DETERMINATION, APPLYING THE TERMS OF THE PLAN TO THE COVERED PERSON'S MEDICAL CIRCUMSTANCES, OR A STATEMENT THAT SUCH EXPLANATION WILL BE PROVIDED FREE OF CHARGE UPON REQUEST.

(III) IN THE EVENT OF AN ADVERSE BENEFIT DETERMINATION BY A GROUP HEALTH BENEFIT PLAN CONCERNING A REQUEST INVOLVING URGENT CARE, A CARRIER:

(A) SHALL PROVIDE A DESCRIPTION OF THE EXPEDITED REVIEW PROCESS APPLICABLE TO SUCH REQUESTS TO THE COVERED PERSON; AND

(B) MAY COMMUNICATE THE OTHER INFORMATION REQUIRED PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH (a) TO THE COVERED PERSON ORALLY WITHIN THE TIME FRAME OUTLINED IN SECTION 10-16-106.5 (4) SO LONG AS A WRITTEN OR ELECTRONIC COPY OF SUCH INFORMATION IS FURNISHED TO THE COVERED PERSON NO LATER THAN THREE DAYS AFTER THE ORAL NOTIFICATION.

(b) (II) The first-level appeal shall be a review by a physician who shall consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the ~~case~~ REQUEST FOR HEALTH BENEFITS being reviewed. The physician and clinical peer or peers shall not have been involved in the initial denial, NOR SHALL SUCH PERSONS BE SUBORDINATES OF ANY PHYSICIAN OR CLINICAL PEER INVOLVED IN THE INITIAL DENIAL. However, a person that was previously involved with the denial may answer questions. A health coverage plan may establish an internal review process that eliminates the first-level review and whereby all appeals are sent directly to a review panel as provided for in this subparagraph (II).

(8) A POLICYHOLDER, INSURED, OR AUTHORIZED REPRESENTATIVE OF THE INSURED MAY CONTEST A DENIAL OF COVERED BENEFITS. FOR THE PURPOSES OF THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES, AN "AUTHORIZED REPRESENTATIVE OF THE INSURED" MAY BE DETERMINED BY REASONABLE POLICIES OF THE CARRIER; EXCEPT THAT, IN THE INSTANCE OF URGENT CARE, A HEALTH CARE PROVIDER WITH KNOWLEDGE OF THE INSURED'S MEDICAL CONDITION MAY BE AN AUTHORIZED REPRESENTATIVE OF THE INSURED.

(9) IN THE CASE OF A REQUEST FOR BENEFITS INVOLVING URGENT CARE, THE CARRIER SHALL NOTIFY THE POLICYHOLDER OR INSURED OF THE CARRIER'S BENEFIT DETERMINATION, WHETHER ADVERSE OR NOT, AS SOON AS POSSIBLE, TAKING INTO ACCOUNT THE MEDICAL EXIGENCIES, BUT NO LATER THAN SEVENTY-TWO HOURS AFTER RECEIPT OF THE REQUEST FOR BENEFITS BY THE CARRIER, UNLESS THE CLAIMANT FAILS TO PROVIDE SUFFICIENT INFORMATION TO DETERMINE WHETHER, OR TO WHAT EXTENT, BENEFITS ARE COVERED OR PAYABLE BY THE CARRIER. IN THE CASE OF SUCH FAILURE, THE CARRIER SHALL NOTIFY THE POLICYHOLDER OR INSURED NO LATER THAN TWENTY-FOUR HOURS AFTER THE DENIAL OF THE SPECIFIC INFORMATION REQUIRED TO COMPLETE THE REQUEST. THE POLICYHOLDER OR INSURED SHALL BE AFFORDED A REASONABLE AMOUNT OF TIME, TAKING INTO ACCOUNT THE CIRCUMSTANCES, BUT NOT LESS THAN FORTY-EIGHT HOURS, TO PROVIDE THE REQUIRED INFORMATION. NOTIFICATION OF ANY ADVERSE BENEFIT DETERMINATION BY THE CARRIER SHALL OCCUR AS SOON AS POSSIBLE, BUT IN NO CASE LATER THAN FORTY-EIGHT HOURS AFTER THE EARLIER OF:

(a) THE CARRIER'S RECEIPT OF THE REQUIRED INFORMATION; OR

(b) THE END OF THE PERIOD AFFORDED THE POLICYHOLDER OR INSURED TO PROVIDE THE REQUIRED INFORMATION.

(10) IN THE CASE OF A REQUEST REQUIRING PREAUTHORIZATION FOR NONEMERGENCY TREATMENT, THE CARRIER SHALL NOTIFY THE POLICYHOLDER OR INSURED OF THE CARRIER'S DETERMINATION, WHETHER ADVERSE OR NOT, WITHIN A REASONABLE PERIOD APPROPRIATE FOR THE MEDICAL CIRCUMSTANCES, BUT NO LATER THAN FIFTEEN DAYS AFTER RECEIPT OF THE REQUEST BY THE CARRIER. THIS PERIOD MAY BE EXTENDED ONE TIME BY THE CARRIER FOR UP TO FIFTEEN DAYS IF THE CARRIER BOTH DETERMINES THAT SUCH AN EXTENSION IS NECESSARY DUE TO MATTERS BEYOND THE CONTROL OF THE CARRIER AND NOTIFIES THE POLICYHOLDER OR INSURED PRIOR TO THE EXPIRATION OF THE INITIAL FIFTEEN-DAY PERIOD OF THE CIRCUMSTANCES REQUIRING THE EXTENSION OF TIME AND THE DATE BY WHICH THE CARRIER EXPECTS TO RENDER A DECISION. IF SUCH EXTENSION IS NECESSARY BECAUSE OF A FAILURE OF THE POLICYHOLDER OR INSURER TO SUBMIT INFORMATION NECESSARY TO DETERMINE THE REQUEST, THE NOTICE OF EXTENSION SHALL SPECIFICALLY DESCRIBE THE REQUIRED INFORMATION, AND THE POLICYHOLDER OR INSURED SHALL BE AFFORDED AT LEAST FORTY-FIVE DAYS FROM THE RECEIPT OF THE NOTICE TO PROVIDE THE REQUIRED INFORMATION.

(11) IN THE CASE OF A POST-SERVICE REQUEST THAT DOES NOT REQUIRE PREAUTHORIZATION BEFORE TREATMENT OR SERVICES ARE RENDERED, THE CARRIER SHALL NOTIFY THE POLICYHOLDER OR INSURED OF THE CARRIER'S ADVERSE BENEFIT DETERMINATION WITHIN A REASONABLE PERIOD, BUT NOT LATER THAN THIRTY DAYS AFTER RECEIPT OF THE REQUEST. THIS PERIOD MAY BE EXTENDED ONE TIME BY THE CARRIER FOR UP TO FIFTEEN DAYS IF THE CARRIER BOTH DETERMINES THAT SUCH AN EXTENSION IS NECESSARY DUE TO MATTERS BEYOND THE CONTROL OF THE CARRIER AND NOTIFIES THE POLICYHOLDER OR INSURED PRIOR TO THE EXPIRATION OF THE INITIAL THIRTY-DAY PERIOD OF THE CIRCUMSTANCES REQUIRING THE EXTENSION OF TIME AND THE DATE BY WHICH THE CARRIER EXPECTS TO RENDER A DECISION. IF SUCH AN EXTENSION IS NECESSARY, DUE TO A FAILURE OF THE POLICYHOLDER OR INSURED TO SUBMIT THE INFORMATION REQUIRED TO DECIDE THE REQUEST, THE NOTICE OF EXTENSION SHALL SPECIFICALLY DESCRIBE THE REQUIRED INFORMATION AND THE POLICYHOLDER OR INSURED SHALL BE AFFORDED AT LEAST FORTY-FIVE DAYS FROM RECEIPT OF THE NOTICE TO PROVIDE THE REQUIRED INFORMATION.

(12) IN THE CASE OF A REQUEST FOR DISABILITY BENEFITS, THE CARRIER SHALL NOTIFY THE POLICYHOLDER OR INSURED OF THE CARRIER'S ADVERSE BENEFIT DETERMINATION WITHIN A REASONABLE PERIOD, BUT NOT LATER THAN FORTY-FIVE DAYS AFTER RECEIPT OF THE REQUEST BY THE CARRIER. THIS PERIOD MAY BE EXTENDED BY THE CARRIER FOR UP TO THIRTY DAYS IF THE CARRIER BOTH DETERMINES THAT SUCH AN EXTENSION IS NECESSARY DUE TO MATTERS BEYOND THE CONTROL OF THE CARRIER AND NOTIFIES THE POLICYHOLDER OR INSURED PRIOR TO THE EXPIRATION DATE OF THE INITIAL FORTY-FIVE-DAY PERIOD OF THE CIRCUMSTANCES REQUIRING THE

EXTENSION OF TIME AND THE DATE BY WHICH THE CARRIER EXPECTS TO RENDER A DECISION. IF, PRIOR TO THE END OF THE FIRST THIRTY-DAY EXTENSION PERIOD, THE CARRIER DETERMINES THAT, DUE TO MATTERS BEYOND THE CONTROL OF THE CARRIER, A DECISION CANNOT BE RENDERED WITHIN THE EXTENSION PERIOD, THE PERIOD FOR MAKING THE DETERMINATION MAY BE EXTENDED FOR UP TO AN ADDITIONAL THIRTY DAYS IF THE CARRIER NOTIFIES THE POLICYHOLDER OR INSURED PRIOR TO THE EXPIRATION OF THE FIRST THIRTY-DAY-EXTENSION PERIOD OF THE CIRCUMSTANCES REQUIRING THE EXTENSION AND THE DATE BY WHICH THE CARRIER EXPECTS TO RENDER A DECISION. IN THE CASE OF ANY EXTENSION UTILIZED UNDER THIS SUBSECTION (12), THE NOTICE OF THE EXTENSION SHALL SPECIFICALLY EXPLAIN THE STANDARDS ON WHICH ENTITLEMENT TO A BENEFIT IS BASED, THE UNRESOLVED ISSUES THAT PREVENT A DECISION ON THE REQUEST, AND THE ADDITIONAL INFORMATION REQUIRED TO RESOLVE THOSE ISSUES. THE POLICYHOLDER OR INSURED SHALL BE AFFORDED AT LEAST FORTY-FIVE DAYS TO PROVIDE ANY REQUIRED INFORMATION.

(13) FOR THE PURPOSES OF SUBSECTIONS (9) TO (12) OF THIS SECTION, THE PERIOD WITHIN WHICH A BENEFIT DETERMINATION IS REQUIRED TO BE MADE SHALL BEGIN AT THE TIME A REQUEST IS FILED IN ACCORDANCE WITH THE REASONABLE PROCEDURES OF THE CARRIER, WITHOUT REGARD TO WHETHER ALL THE INFORMATION REQUIRED TO MAKE A BENEFIT DETERMINATION ACCOMPANIES THE FILING. IN THE EVENT THAT A PERIOD IS EXTENDED AS PERMITTED PURSUANT TO SUBSECTIONS (9) TO (12) OF THIS SECTION, DUE TO THE POLICYHOLDER'S OR INSURED'S FAILURE TO SUBMIT INFORMATION NECESSARY TO DECIDE THE REQUEST, THE PERIOD FOR MAKING THE BENEFIT DETERMINATION SHALL BE TOLLED FROM THE DATE ON WHICH THE NOTIFICATION OF THE EXTENSION IS SENT TO THE POLICYHOLDER OR INSURED UNTIL THE DATE ON WHICH THE POLICYHOLDER OR INSURED RESPONDS TO THE REQUEST FOR ADDITIONAL INFORMATION.

SECTION 2. 10-16-705 (14), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

10-16-705. Requirements for carriers and participating providers. (14) Every contract between a carrier or entity that contracts with a carrier and a participating provider for a managed care plan that requires preauthorization for particular services, treatments, or procedures shall include:

(c) A PROVISION NOTIFYING THE COVERED PERSON THAT THE PROVIDER HAS FAILED TO FOLLOW PROPER PROCEDURES FOR FILING A REQUEST FOR BENEFITS. SUCH NOTIFICATION SHALL OCCUR AS SOON AS POSSIBLE, BUT NOT LATER THAN FIVE DAYS AFTER SUCH FAILURE FOR NONEMERGENCY SERVICES OR TWENTY-FOUR HOURS AFTER SUCH FAILURE FOR EMERGENCY SERVICES.

SECTION 3. Effective date - applicability. (1) This act shall take effect January 1, 2004, 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 I (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 health insurance policies issued or renewed on or after the applicable effective date of this act.

DRAFT

Colorado Legislative Council Staff

NO FISCAL IMPACT

Drafting Number:	LLS 03-0092	**Date:**	November 5, 2002
Prime Sponsor(s):	Rep. Spradley Sen. Hagedorn	**Bill Status:**	Health Care Systems Interim Committee
		Fiscal Analyst:	Janis Baron (303-866-3523)

TITLE: CONCERNING THE IMPLEMENTATION OF THE FEDERAL "EMPLOYEE RETIREMENT INCOME SECURITY ACT" WITH REGARD TO THE ADMINISTRATION OF REQUESTS FOR HEALTH BENEFITS.

Summary of Assessment

The bill reconciles current law regarding administrative procedures for denial of health plans' benefits for insured members with the federal Employee Retirement Income Security Act (ERISA) requirements regarding such denials. The bill is effective January 1, 2004, unless a referendum petition is filed during the 90-day period following final adjournment of the General Assembly.

Presently, the bill is assessed at having no state or local fiscal impact. Although the Department of Regulatory Agencies, Division of Insurance, will incur minimal costs to comply with the bill's requirements (rule promulgation and public comment), the fiscal note assumes that these costs can be absorbed within existing appropriations.

Departments Contacted

Health Care Policy and Financing Personnel Regulatory Agencies PERA

Bill E

SENATE SPONSORSHIP

Hanna

HOUSE SPONSORSHIP

Tochtrop

A BILL FOR AN ACT

CONCERNING REIMBURSEMENT TO THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FOR MEDICATIONS THAT ARE RETURNED UNDER THE "COLORADO MEDICAL ASSISTANCE ACT".

Bill Summary

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

Health Care Systems Interim Committee. Requires providers of pharmaceutical services to reimburse the department of health care policy and financing ("department") for the cost of medications that the department has paid to the provider of pharmaceuticals and that are returned by health care providers, if those medications are available to be dispensed to another person. Specifies conditions under which the medications may be available to be dispensed to another person.

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

SECTION 1. Part 4 of article 4 of title 26, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-406.5. Provider of pharmaceutical services - reimbursement for unused medications - rules. (1) A PROVIDER OF PHARMACEUTICAL SERVICES SHALL REIMBURSE THE STATE DEPARTMENT FOR THE COST OF MEDICATIONS THAT THE STATE DEPARTMENT HAS PAID TO THE PROVIDER OF PHARMACEUTICALS IF THE HEALTH CARE PROVIDER RETURNS THE MEDICATIONS TO THE PROVIDER AND IF THE MEDICATIONS ARE AVAILABLE TO BE DISPENSED TO ANOTHER PERSON. MEDICATIONS SHALL ONLY BE AVAILABLE TO BE DISPENSED TO ANOTHER PERSON UNDER THIS SECTION IF THE MEDICATIONS ARE INDIVIDUALLY PACKAGED AND THE PACKAGING HAS NOT BEEN DAMAGED.

(2) SAVINGS REALIZED THROUGH REIMBURSEMENTS RECEIVED PURSUANT TO SUBSECTION (1) OF THIS SECTION SHALL FUND THE ADMINISTRATION OF THIS SECTION. ANY SAVINGS REALIZED IN EXCESS OF THE COST OF THE ADMINISTRATION OF THIS SECTION SHALL REMAIN WITHIN THE MEDICAID PROGRAM TO PROVIDE MEDICAL SERVICES TO MEDICAL ASSISTANCE RECIPIENTS.

(3) THE STATE BOARD SHALL PROMULGATE ANY NECESSARY RULES TO IMPLEMENT THIS SECTION.

SECTION 2. Effective date. This act shall take effect July 1, 2003.

SECTION 3. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

DRAFT

Bill E

Colorado Legislative Council Staff

STATE FISCAL IMPACT

Drafting Number:	LLS 03-0133	**Date:**	December 3, 2002
Prime Sponsor(s):	Rep. Tochtrop Sen. Hanna	**Bill Status:**	Health Care Systems Interim Committee
		Fiscal Analyst:	Janis Baron (303-866-3523)

TITLE: CONCERNING REIMBURSEMENT TO THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FOR MEDICATIONS THAT ARE RETURNED UNDER THE "COLORADO MEDICAL ASSISTANCE ACT".

Fiscal Impact Summary	FY 2003/2004	FY 2004/2005
State Revenues General Fund		
State Expenditures General Fund* Federal Fund	 $ 6,583 37,880	 ($ 18,121) 19,521
FTE Position Change	0.0 FTE	0.0 FTE
Other State Impact: None		
Effective Date: July 1, 2003		
Appropriation Summary for FY 2003/2004: Department of Health Care Policy and Financing	$ 44,463 Total 6,583 General Fund 37,880 Federal Funds	
Local Government Impact: None		

* In FY 2004-05, these General Fund savings remain in the Department of Health Care Policy and Financing for medical services.

Summary of Legislation

The bill requires pharmacy providers to reimburse the Department of Health Care Policy and Financing (DHCPF) for the cost of medications paid to them by the department if such medications are returned by health care providers and are available to be dispensed to others. Only those medications that are individually packaged and not damaged can be dispensed to another person. Savings realized through reimbursements received shall be used to fund the administrative costs of this program; any savings in excess of the administrative costs shall remain in the Medicaid program for medical services.

State Expenditures

The bill's fiscal impact is estimated at $44,463 in FY 2003-04 and $1,400 in FY 2004-05. The bill results in both costs and savings. The bill's fiscal impact is based on the assumptions noted below. The assumptions are based, in large part, on the experience of other states with comparable programs.

- ➔ The DHCPF will take returns from non-retail pharmacies **only**, not retail pharmacies. The program will include Class I Nursing Facility clients only — clients without direct access to their medications. Institutions get the majority of their drugs from non-retail pharmacies in blister packs.

- ➔ Returns — medications must be returned in sealed individually packaged units; no expired packages may be returned for credit; the date of return can be no longer than 3 months from the date of packaging; and returned prescriptions must have a minimum value of $5 to be included in the program.

- ➔ All controlled substances will be excluded from the program; 25% of current non-controlled prescription drugs in Medicaid nursing facilities will be eligible for return and redispensing. Of the 25%, only partial prescriptions will be returned and adjustments must be made to the total eligible drug expenditures.

- ➔ Returned unused drugs will save 10% of the total eligible drug expenditures for Class I Nursing Facility clients.

- ➔ The program will be implemented March 1, 2003, after completing the necessary systems changes.

Costs. Costs are incurred in the Medicaid Management Information System (MMIS) for systems changes (300 hours @ $125/hour = $37,500 in year one only) and ongoing claims processing charges ($25,094 in year one and $75,282 in year two). Additionally, the fiscal note assumes that pharmacy providers will be paid a reimbursement incentive fee of $4 to return unused medications and reimburse the state the amount of such unused medications. The fiscal note uses a $4 fee which is equal to the current dispensing fee. Incentive fee payments are estimated at $198,405 in FY 2003-04 and $595,216 in FY 2004-05.

Savings. Total savings are estimated at $216,537 in FY 2003-04 and $669,098 in FY 2004-05. Savings in both fiscal years are calculated off an estimated annual base (FY 2002-03) of $26.0 million for non-controlled substance medications for nursing facility clients. Savings in year one represent 4 months of program implementation; savings in year two represent 12 months and reflect a 3 percent inflationary factor. In year one, total costs exceed savings by $44,463. In year two, only General Fund savings exceed costs by $18,121. As stipulated in the bill, the fiscal note assumes that these savings will remain in the DHCPF for medical services.

Funding. MMIS costs are funded 25 percent General Fund and 75 percent federal funds. Incentive fee payments and savings in total eligible drug expenditures are 50 percent General Fund and 50 percent federal funds.

State Appropriations

The fiscal note indicates that the Department of Health Care Policy and Financing should receive an appropriation for $44,463 in FY 2003-04. Of the total amount, $6,583 is General Fund and $37,880 is federal funds.

Departments Contacted

Health Care Policy and Financing

Regulatory Agencies

Bill F

SENATE SPONSORSHIP

Hillman

HOUSE SPONSORSHIP

Williams T., and Clapp

A BILL FOR AN ACT

CONCERNING THE PROHIBITION OF THE CORPORATE PRACTICE OF MEDICINE BY A PROFESSIONAL SERVICES CORPORATION FORMED BY PERSONS LICENSED TO PRACTICE MEDICINE.

Bill Summary

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

Health Care Systems Interim Committee. Clarifies that a professional services corporation formed by persons licensed to practice medicine may not engage in the corporate practice of medicine. Provides that a professional services corporation may not control the physician's independent professional judgment.

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

SECTION 1. The introductory portion to 12-36-134 (1), 12-36-134 (1) (b) and (1) (f), the introductory portion to 12-36-134 (1) (g), and 12-36-134 (3) and (7), Colorado Revised Statutes, are amended to read:

12-36-134. Professional service corporations, limited liability companies, and registered limited liability partnerships for the practice of medicine - definitions. (1) Persons licensed to practice medicine by the board may form professional service corporations for ~~the~~ SUCH PERSONS' practice of medicine under the "Colorado Corporation Code", if such corporations are organized and operated in accordance with the provisions of this section. The articles of incorporation of such corporations shall contain provisions complying with the following requirements:

(b) The corporation shall be organized solely for the ~~purposes of conducting the practice of medicine only through~~ PURPOSE OF persons licensed by the board to practice medicine in the state of Colorado TO CONDUCT THE PRACTICE OF MEDICINE.

(f) The president shall be a shareholder and a director and, to the extent possible, all other directors and officers shall be persons having the qualifications described in paragraph (d) of this subsection (1). Lay directors and officers shall not exercise any authority whatsoever over professional matters. Notwithstanding sections 7-108-103 to 7-108-106, C.R.S., relating to the terms of office and classification of directors, a professional service corporation for the practice of medicine may provide in the articles of incorporation or the bylaws that the directors may have terms of office of up to six years and that the directors may be divided into either two or three classes,

each class to be as nearly equal in number as possible, with the terms of each class staggered to provide for the periodic, but not annual, election of less than all the directors. NOTHING IN THIS PARAGRAPH (f) SHALL BE CONSTRUED TO PERMIT A PROFESSIONAL SERVICE CORPORATION TO EXERCISE AUTHORITY OR CONTROL OVER A PHYSICIAN'S INDEPENDENT MEDICAL JUDGMENT.

(g) The articles of incorporation shall provide and all shareholders of the corporation shall agree that all shareholders of the corporation shall be jointly and severally liable for all acts, errors, and omissions of the employees of the corporation or that all shareholders of the corporation shall be jointly and severally liable for all acts, errors, and omissions of the employees of the corporation except during periods of time when each person licensed by the board to practice medicine in Colorado who is a shareholder or any employee of the corporation has a professional liability policy insuring himself OR HERSELF and all employees who are not licensed to practice medicine who act at his OR HER direction in the amount of fifty thousand dollars for each claim and an aggregate top limit of liability per year for all claims of one hundred fifty thousand dollars or the corporation maintains in good standing professional liability insurance which shall meet the following minimum standards:

(3) The corporation shall do nothing which, if done by a person licensed to practice medicine in the state of Colorado employed by it, would violate the standards of professional conduct as provided for in section 12-36-117. Any violation by the corporation of this section shall be grounds for the board to terminate or suspend ~~its right to practice medicine~~ THE PERSON OR PERSONS RESPONSIBLE FOR THE VIOLATION FROM THE PRACTICE OF MEDICINE.

(7) (a) ~~Except as provided in this section.~~ Corporations shall not practice medicine. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW ANY PROFESSIONAL SERVICE CORPORATION WHICH EMPLOYS A PHYSICIAN TO LIMIT OR OTHERWISE EXERCISE CONTROL OVER THE PHYSICIAN'S INDEPENDENT PROFESSIONAL JUDGMENT CONCERNING THE PRACTICE OF MEDICINE OR DIAGNOSIS OR TREATMENT. ANY PROFESSIONAL SERVICE CORPORATION THAT KNOWINGLY OR RECKLESSLY SO LIMITS OR CONTROLS A PHYSICIAN IN SUCH MANNER OR ATTEMPTS TO DO SO MAY BE HELD LIABLE TO THE PATIENT OR THE PHYSICIAN, OR BOTH, FOR SUCH VIOLATIONS, INCLUDING PROXIMATELY CAUSED DAMAGES. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO AFFECT ANY PROFESSIONAL SERVICE CORPORATION'S DECISIONS WITH RESPECT TO THE AVAILABILITY OF SERVICES, TECHNOLOGY, EQUIPMENT, FACILITIES, OR TREATMENT PROGRAMS, OR AS REQUIRING ANY SUCH PROFESSIONAL SERVICE CORPORATION TO MAKE AVAILABLE TO PATIENTS OR PHYSICIANS ADDITIONAL SERVICES, TECHNOLOGY, EQUIPMENT, FACILITIES, OR TREATMENT PROGRAMS.

(b) IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT THIS SECTION NOT ABROGATE THE CORPORATE PRACTICE OF MEDICINE DOCTRINE IN THIS STATE. NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, THIS SECTION SHALL BE CONSTRUED TO PRECLUDE A PROFESSIONAL SERVICES

CORPORATION FROM CONTROLLING THE INDEPENDENT MEDICAL JUDGMENT OF A PHYSICIAN AND FROM BEING LIABLE FOR THE TORTS OF PHYSICIAN EMPLOYEES, EXCEPT AS OTHERWISE PROVIDED IN PARAGRAPH (a) OF THIS SUBSECTION (7).

(c) Employment of a physician in accordance with section 25-3-103.7, C.R.S., shall not be considered the corporate practice of medicine.

SECTION 2. 12-36-117 (1) (m), Colorado Revised Statutes, is amended to read:

12-36-117. Unprofessional conduct. (1) "Unprofessional conduct" as used in this article means:

(m) (I) Except as otherwise provided in section 25-3-103.7 and section 25-3-314, C.R.S., practicing medicine as the partner, agent, or employee of, or in joint adventure with, any person who does not hold a license to practice medicine within this state, or practicing medicine as an employee of, or in joint adventure with, any partnership or association any of whose partners or associates do not hold a license to practice medicine within this state, or practicing medicine as an employee of or in joint adventure with any corporation other than a professional service corporation for the practice of medicine as ~~defined~~ DESCRIBED in section 12-36-134. Any licensee holding a license to practice medicine in this state may accept employment from any person, partnership, association, or corporation to examine and treat the employees of such person, partnership, association, or corporation.

(II) (A) NOTHING IN THIS PARAGRAPH (m) SHALL BE CONSTRUED TO PERMIT A PROFESSIONAL SERVICES CORPORATION FOR THE PRACTICE OF MEDICINE, AS DESCRIBED IN SECTION 12-36-134, TO PRACTICE MEDICINE.

(B) NOTHING IN THIS PARAGRAPH (m) SHALL BE CONSTRUED TO OTHERWISE CREATE AN EXCEPTION TO THE CORPORATE PRACTICE OF MEDICINE DOCTRINE.

SECTION 3. 13-64-202 (4), Colorado Revised Statutes, is amended to read:

13-64-202. Definitions. As used in this part 2, unless the context otherwise requires:

(4) (a) "Health care professional" means any person licensed in this state or any other state to practice medicine, chiropractic, nursing, physical therapy, podiatry, dentistry, pharmacy, optometry, or other healing arts. The term includes any professional corporation or other professional entity comprised of such health care providers as permitted by the laws of this state.

(b) Repealed.

(c) (I) NOTHING IN THIS SUBSECTION (4) SHALL BE CONSTRUED TO PERMIT A PROFESSIONAL SERVICE CORPORATION FOR THE PRACTICE OF MEDICINE, AS DESCRIBED IN SECTION 12-36-134, C.R.S., TO PRACTICE MEDICINE.

(II) NOTHING IN THIS SUBSECTION (4) SHALL BE CONSTRUED TO OTHERWISE CREATE AN EXCEPTION TO THE CORPORATE PRACTICE OF MEDICINE DOCTRINE.

SECTION 4. 13-64-403 (12) (a), Colorado Revised Statutes, is amended to read:

13-64-403. Agreement for medical services - alternative arbitration procedures - form of agreement - right to rescind. (12) For the purposes of this section:

(a) (I) "Health care provider" means any person licensed or certified by the state of Colorado to deliver health care and any clinic, health dispensary, or health facility licensed by the state of Colorado. The term includes any professional corporation or other professional entity comprised of such health care providers as permitted by the laws of this state.

(II) (A) NOTHING IN THIS PARAGRAPH (a) SHALL BE CONSTRUED TO PERMIT A PROFESSIONAL SERVICE CORPORATION FOR THE PRACTICE OF MEDICINE, AS DESCRIBED IN SECTION 12-36-134, C.R.S., TO PRACTICE MEDICINE.

(B) NOTHING IN THIS PARAGRAPH (a) SHALL BE CONSTRUED TO OTHERWISE CREATE AN EXCEPTION TO THE CORPORATE PRACTICE OF MEDICINE DOCTRINE.

SECTION 5. Effective date - applicability. This act shall take effect July 1, 2003, and shall apply to acts or omissions occurring on or after said date.

SECTION 6. 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 03-0135	**Date:**	November 1, 2002
Prime Sponsor(s):	Rep. Williams T. Sen. Hillman	**Bill Status:**	Health Care Systems Interim Committee
		Fiscal Analyst:	Janis Baron (303-866-3523)

TITLE: CONCERNING THE PROHIBITION OF THE CORPORATE PRACTICE OF MEDICINE BY A PROFESSIONAL SERVICES CORPORATION FORMED BY PERSONS LICENSED TO PRACTICE MEDICINE.

Summary of Assessment

The bill clarifies that a professional service corporation formed by persons licensed to practice medicine shall not engage in the corporate practice of medicine. Additionally, a professional service corporation is not allowed to exercise control over the physician's independent professional judgment concerning the practice of medicine, diagnosis, or treatment. The bill includes an effective date of July 1, 2003, and applies to acts or omissions occurring on or after that date.

The bill is assessed at having no fiscal impact. The bill clarifies the law regarding professional service corporations for persons practicing medicine and the prohibition of the corporate practice of medicine.

Departments Contacted

Judicial Regulatory Agencies

Bill G

SENATE SPONSORSHIP

Owen and Hanna

HOUSE SPONSORSHIP

Jahn and Tochtrop

A BILL FOR AN ACT

CONCERNING DISCLOSURE BY A HEALTH CARE PROVIDER TO THE NAMED INSURED OF THE ESTIMATED CHARGES FOR NONEMERGENCY PROCEDURES PRIOR TO THE SCHEDULING OF SUCH PROCEDURES.

Bill Summary

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

Health Care Systems Interim Committee. Makes legislative findings. Requires health care providers to disclose to patients, prior to the scheduling of a nonemergency procedure, the estimated cost of the procedure that would be billed to the patient.

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

SECTION 1. Legislative findings. The general assembly hereby finds, determines, and declares that consumers of health care services are not adequately informed as to the costs associated with health care services and therefore frequently choose services that may not be the most cost-effective or efficacious, thus contributing to the growing cost of health care. Therefore, the general assembly declares that health care providers should inform consumers of health care of the estimated costs associated with nonemergency procedures in advance. Such disclosure will provide more autonomy to consumers of health care and may help contain the spiraling costs of such care.

SECTION 2. 10-16-705, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-16-705. Requirements for carriers and participating providers.

(17) EACH PARTICIPATING PROVIDER CONTRACTING WITH A CARRIER SHALL DISCLOSE TO THE NAMED INSURED THE ESTIMATED COSTS OF ANY NONEMERGENCY PROCEDURE ORDERED BY THE PROVIDER PRIOR TO SCHEDULING SUCH PROCEDURE.

SECTION 3. Effective date - applicability. This act shall take effect January 1, 2004, and shall apply to health benefit plans issued or renewed on or after said date.

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

DRAFT

Colorado Legislative Council Staff

NO FISCAL IMPACT

Drafting Number:	LLS 03-0168	**Date:**	October 31, 2002
Prime Sponsor(s):	Sen. Owen Rep. Jahn	**Bill Status:**	Health Care Systems Interim Committee
		Fiscal Analyst:	Janis Baron (303-866-3523)

TITLE: CONCERNING DISCLOSURE BY A HEALTH CARE PROVIDER TO THE NAMED INSURED OF THE ESTIMATED CHARGES FOR NONEMERGENCY PROCEDURES PRIOR TO THE SCHEDULING OF SUCH PROCEDURES.

Summary of Assessment

The bill requires health care providers contracting with a carrier to disclose the estimated costs of any nonemergency procedure ordered by the provider prior to scheduling such procedure. The bill has an effective date of January 1, 2004, and applies to health benefit plans issued or renewed on or after that date.

The bill is assessed at having no fiscal impact. The Department of Regulatory Agencies, Division of Insurance, indicates that its oversight of provider contracts is through its Market Conduct section. The section currently monitors several required provisions, and can monitor this requirement as part of the department's ongoing workload.

Departments Contacted

Health Care Policy and Financing Personnel Regulatory Agencies