0568 Health Care Task Force

Colorado Legislative Council

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0568 Health Care Task Force
December 2007

To Members of the Sixty-sixth General Assembly:

Submitted herewith is the final report of the Health Care Task Force. This committee was created pursuant to Section 10-16-221, C.R.S. The purpose of the committee is to study provider reimbursement issues, network adequacy, and other health care issues that affect health insurance in the state.

At its meeting on November 15, the Legislative Council reviewed the report of this committee. A motion to forward this report and the bills therein for consideration in the 2008 session was approved.

Respectfully Submitted,

/s/ Senator Peter Groff
Chairman
Health Care Task Force

Members of the Committee

Senator Betty Boyd, Chair
Representative Jim Riesberg, Vice-Chair

Senator Mike Kopp
Senator John Morse
Senator David Schultheis
Senator Brandon Shaffer

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This report is also available online at:

[http://www.state.co.us/gov_dir/leg_dir/lcsstaff/2007/07interim.htm](http://www.state.co.us/gov_dir/leg_dir/lcsstaff/2007/07interim.htm)
Executive Summary

Committee Charge

Pursuant to Section 10-16-221, C.R.S., the Health Care Task Force is charged with studying provider reimbursement issues, network adequacy, and other health care issues that affect health insurance in this state. The task force must meet at least four times each year, and continues until July 1, 2010.

Committee Activities

The Health Care Task Force met five times during the 2007 interim. Each meeting focused on a variety of health-related topics. The task force heard testimony from health care providers, advocacy organizations, authors of the proposed health care reform plans, representatives involved in health information technology, and executive department heads. In addition, an opportunity for public testimony was provided at the conclusion of the last meeting.

*Trauma care.* Representatives from the Emergency Medical and Trauma Service and Health Facilities Division within the Department of Public Health and Environment (DPHE) and the Colorado State Fire Chief's Association discussed their respective roles in the trauma care system. Trauma care providers addressed the impact from the change in 2003 from a no-fault to a tort auto insurance system on trauma care facilities and paramedic services. In the last four years, trauma care providers have struggled with reimbursement delays since payment for services is not disbursed until the at-fault party is identified. Further, individuals with insufficient or no health insurance are often unable to pay for emergency services and providers have seen a cost shift to Medicaid. The committee discussed options for improving reimbursement for providers through various methods, including an increase in vehicle registration fees to fund a trauma care reimbursement program, and requiring medical payments coverage as part of an auto insurance policy. As a result of these discussions, the committee proposes Bills D and E. Bill D requires auto insurance policies to contain at least $15,000 emergency medical care coverage to cover the costs of all medically necessary and accident-related health care services. Bill E establishes an Emergency Responders and Trauma Care Reimbursement Program to be funded by an increase in the fee for registering a motor vehicle, and requires auto insurance policies to contain $15,000 of emergency medical care coverage.

*Emergency preparedness.* The task force heard from the DPHE, Denver Health, and University of Colorado Hospital about Colorado's preparedness for a catastrophic health-related event, such as a pandemic flu outbreak or bio-terrorist attack. Among the items discussed were individual plans for addressing such an event; strategies for educating the public during an outbreak; quarantine planning; and methods for vaccine prioritization.

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1 Up until its repeal on July 1, 2004, the Health Care Task Force existed in Section 26-15-107, C.R.S. The Health Care Task Force was reinstated in 2005 with the passage of Senate Bill 05-227.
Blue Ribbon Commission for Health Care Reform. The Blue Ribbon Commission for Health Care Reform is referred to as the 208 Commission after Senate Bill 06-208 that created the commission. The commission’s charge is to evaluate comprehensive health care reform in Colorado with the goal of increasing health care coverage and decreasing costs for Colorado residents, with an emphasis on the underinsured and uninsured. The task force heard testimony from the commission and the authors of the four proposals selected by the commission outlining plans for health care reform in Colorado. Each author provided information about each plan with regard to design, plan coverage, the projected number of individuals in Colorado insured under each plan, and financing details including costs to the state and potential federal funding. The task force also learned about a fifth proposal authored by the commission. The commission will present a full report on the five proposals with highlights and recommendations to the House and Senate Health and Human Services committees on January 31, 2008.

Health information technology. The task force discussed recent developments in health information technology including the use of electronic medical records and medication management. Representatives from Kaiser Permanente and Colorado Clinical Guidelines demonstrated their medical records systems. In addition, the committee discussed current programs that are being developed in an attempt to link the various electronic medical record systems together. Members of the Colorado Regional Health Information Organization (CORHIO) explained their efforts to create a statewide network for the exchange of electronic health information, including links between an array of providers, organizations, and networks throughout the state, and eventually to other states as well. Representatives of retail pharmacies talked to the task force about the benefits of reviewing medication therapy with clients, maintaining personal medication records for historical reference, and upkeep of medication action plans. As a result of prior discussions of the Health Care Task Force in 2006, the Prescription Drug Information and Technical Assistance Program was established within the Department of Health Care Policy and Financing (DHCPF) to provide advice about prescription drugs to Medicaid clients. The department administers the program and provides payments to pharmacists and physicians who consult with Medicaid clients about how to avoid dangerous drug interactions, improve outcomes, and save money. Bill A extends the current program to include all programs that provide drug benefits and that are administered by the DHCPF.

Other health-related issues. Throughout the interim, the task force touched on a number of other health-related issues including health disparities, provider shortages, cost drivers, and Medicaid pharmaceutical reimbursement. The task force heard from the Office of Health Disparities within the DPHE about the office’s responsibilities and the 2005 Racial and Ethnic Health Disparities in Colorado report. The task force also discussed nursing and physician shortages in Colorado due to increased utilization of health services; more chronic conditions, such as diabetes, asthma, and obesity; an increase in the aging population; and an increased life expectancy.

Representatives from the pharmaceutical industry expressed concerns over proposed cuts for Medicaid prescription drug reimbursement. As a result of this discussion, the task force is proposing Bill C which increases the dispensing fees paid to pharmacies for the remainder of FY 2007-08 to offset the reduction in the reimbursement rates. The task force also proposes Bill B, which would direct the DHCPF to seek a federal waiver to establish family planning services to categorically eligible individuals who are at or below an unspecified percentage of the federal poverty level. By not specifying a percentage of the federal poverty level, income limitations for eligibility are removed. The percentage of the federal poverty level will be determined by the Centers for Medicaid and Medicare and the DHCPF.
Committee Recommendations

As a result of task force discussion and deliberation, the task force recommends five bills for consideration in the 2008 legislative session.

**Bill A — Medication Therapy Management.** Bill A allows the Department of Health Care Policy and Financing to expand the Prescription Drug Information and Technical Assistance program from Medicaid clients to include persons receiving drug benefits under any program that is administered by the department.

**Bill B — Family Planning Pilot Program.** In 1999, the Family Planning Pilot program was established to provide family planning services to individuals who are categorically eligible for Medicaid and are at or below 150 percent of the federal poverty level. The 1999 bill that was signed into law required the DHCPF to seek a federal waiver to implement the pilot program and stipulated that without a federal waiver the pilot program could not be implemented. Although the Family Planning Pilot program was established, the DHCPF did not seek a federal waiver to implement the program. Bill B directs the DHCPF to again seek a federal waiver to establish family planning services for categorically eligible individuals who are at or below a percentage of the federal poverty level. The bill does not specify the percentage of the federal poverty level, essentially removing the income limitations for eligibility. The percentage of the federal poverty level established in the federal waiver will be decided upon by the Centers for Medicaid and Medicare and the DHCPF.

**Bill C — Payments to Pharmacies for Medicaid Drugs.** Bill C requires the DHCPF to review and calculate the impact of a proposed reduction in reimbursement rates for dispensing Medicaid prescription drug scripts within 30 days after the implementation of changes to reimbursement rates. The proposed reduction in reimbursement rates are a result of the requirements in the federal "Deficit Reduction Act of 2005." The bill directs the DHCPF to increase reimbursement for dispensing fees of Medicaid prescription drug scripts within 45 after the implementation of changes in reimbursement rates by an amount that would approximate the difference in reimbursements paid to pharmacies for the remainder of the 2007-08 fiscal year.

**Bill D — Emergency Medical Care Coverage Auto Insurance.** Bill D requires all auto insurance policies issued, delivered, or renewed on or after January 1, 2009, in the state to include a minimum of $15,000 in emergency medical care coverage for all medically necessary and accident-related health care services within three years of the accident. The bill stipulates that any medically necessary and accident-related emergency medical care provided to a person claiming emergency medical care coverage by a first responder, trauma physician, trauma center, or emergency department of a licensed or certified hospital, must be reimbursed at the rate of 200 percent of the 2006 Medicare Resource-based Relative Value Scale fee schedule. If an insurer fails to include emergency medical care coverage in an auto insurance policy, the minimum coverage amount is presumed to be provided by the insurer.

**Bill E — Trauma Care Funding.** Bill E creates the Emergency Responders and Trauma Care Reimbursement Program and fund in the DPHE. The fund will be used to provide reimbursement of uncompensated trauma care to ambulance companies, trauma physicians, and trauma centers for care of individuals injured in an auto accident. Money for the fund will be collected via an additional $16 vehicle registration fee beginning July 1, 2008. The bill further requires that all auto insurance policies written in the state include a minimum of $15,000 in...
emergency medical care coverage for all medically necessary and accident-related health care services. The bill makes emergency medical care coverage primary coverage for health care provided as a result of an auto accident. Finally, the bill requires the program administrator to provide an annual report to the House and Senate Health and Human Services Committees that includes detailed information regarding:

- the total number of reimbursement applications received;
- the number and types of providers who apply for reimbursement;
- the total amount of reimbursement payments made;
- the recipients of reimbursement payments;
- the total amount of moneys credited to, and expended from, the fund;
- any balance remaining in the fund at the end of the fiscal year;
- the total amount of moneys recovered by the administrator from trauma patients or other parties;
- any recommendations for changes to the program; and
- any other information the program administrator deems appropriate or that the committee requests.
Committee Charge

Pursuant to Section 10-16-221, C.R.S., the Health Care Task Force must consider a variety of issues between July 1, 2005 and July 1, 2010, that include, but are not limited to the following:

- health care issues that may affect health insurance;
- emerging trends in Colorado health care and their impacts on consumers, including, but not limited to:
  - changes in relationships among health care providers, patients, and payors;
  - restrictions in health care options available to consumers;
  - professional liability issues arising from such restrictions;
  - medical and patient record confidentiality;
  - health care work force requirements; and
  - home care in the continuum of care;
- the ability of consumers to obtain and keep adequate, affordable health insurance coverage, including coverage for catastrophic illnesses;
- the effect of managed care on the ability of consumers to obtain timely access to quality care;
- the effect of recent shifts in the way health care is delivered and paid for;
- the operation of the program for the medically indigent in order to give guidance and direction to the Department of Health Care Policy and Financing in the development and operation of such programs;
- future trends for health care coverage rates for employees and employers;
- costs and benefits of providing preventive care and early treatment for people with chronic illnesses who may eventually need long-term care;
- rural health care issues;
- options for addressing needs of the uninsured population;
- network adequacy and the adequacy of access to providers;
- reimbursement processes for health care services by third-party payors and cooperation between providers and carriers;
- certificates of need;
- increased access to health care through the use of appropriate communication technologies, including the use of telemedicine; and
- the establishment of a new system to reimburse emergency responders and trauma care providers for unreimbursed costs.

Senate Bill 07-074 required, during the 2007 interim, to examine and make recommendations concerning issues related to advancing electronic medical records systems and implementation of an interoperable, statewide electronic health information exchange, including but not limited to:

- privacy and security concerns;
- the benefits to public medical assistance programs participating in an electronic health information exchange;
- accessibility of electrocardiogram tracing by emergency treatment facilities;
- priorities for implementing a statewide electronic health information exchange to improve health care safety, quality, and cost-effectiveness;
- how western states can leverage resources and influences to advance regional and national electronic health information exchanges; and
- the benefits of an electronic health information exchange for Colorado's health care reform efforts.

Health Care Task Force
Committee Activities

The committee met five times during the 2007 interim. At these hearings, the committee received briefings on a broad range of health-related topics. The task force heard testimony from health care providers, advocacy organizations, authors of several proposed statewide health care reform plans, representatives involved in health information technology, and executive directors of the state departments.

Trauma Care

Representatives of the Emergency Medical and Trauma Service and Health Facilities Division within the Department of Public Health and Environment and the Colorado State Fire Chief's Association discussed their respective roles in the state trauma care system.

The Chief of the Emergency Medical and Trauma Service and Health Facilities Division discussed the role of the division and its various responsibilities including trauma center designation, administration of emergency medical services (EMS) grants, and emergency medical technician (EMT) certification. The task force heard a history of the state trauma services program and learned the different levels of trauma center designation and the hospital requirements at each designation level. In addition, there was a brief discussion of the division's spending authority. The division uses its funding for EMT education and certification and EMS provider grants as well as distributing money to the Regional Emergency Trauma Advisory Councils that provide technical assistance throughout the state. The division collects fees from hospitals for trauma center certification, however, that money is used to administer the certification process.

Trauma care providers addressed the impact on trauma care facilities and paramedic services as a result of auto insurance's change from a no-fault to a tort system. In the last four years, trauma care providers have struggled with reimbursement delays as payment for services is not disbursed until the at-fault party is identified. Further, individuals with insufficient or no health insurance are often unable to pay for emergency services and providers have seen a shift of costs to Medicaid. The task force heard from advocates representing the state fire chiefs about the role of fire services in the state trauma care system. Fire services providers are generally the first responders, along with police, at the scene of an accident. The task force also heard about the continuum of trauma care from first responders to emergency rooms and outpatient therapy. Providers expressed concern that nursing shortages and other provider shortages, coupled with inadequate funding to the trauma system, would make it difficult for the state to respond to a mass casualty situation effectively due to insufficient staff to respond.

Committee recommendations. As a result of these discussions, the task force discussed options for improving reimbursement for providers through various methods including an increase in vehicle registration fees to fund a trauma care reimbursement program and requiring medical payments coverage as part of an auto insurance policy. The task force recommends Bill D, which will require all auto insurance policies to provide a minimum of $15,000 in emergency medical care coverage and Bill E, which will also require policies to provide emergency medical coverage and creates an Emergency Responders and Trauma Care Reimbursement Fund within the Department of Public Health and Environment.
Emergency Preparedness

Representatives from the DPHE, Denver Health, and University of Colorado Hospital provided information to the task force about Colorado's preparedness with regard to a catastrophic health-related event, such as a pandemic flu outbreak or bio-terrorist attack. The Chief Medical Examiner of the Office of Emergency Preparedness and Response, DPHE, addressed the emergency response responsibilities of the state government in the event of a major health-related incident and discussed the department's strategies for dealing with a pandemic flu outbreak. The DPHE currently has a stockpile of vaccines that would cover hospital patients, high-risk individuals, and health care providers, but the office is considering how many more vaccines to purchase and the method of disbursement of those additional vaccines. Staff from the Office of Emergency Preparedness and Response believe that there are enough hospital beds available in the Denver metro area if such an event occurred; however, there are concerns about medical provider shortages to treat individuals affected.

A Denver Health representative described how Denver Health is preparing for a large scale emergency, such as an outbreak of the pandemic flu. These efforts include testing an automated phone system that could be used to check on individuals in quarantine, or that would allow individuals to check on the status of an outbreak by using their zip code as well as "surge" strategies to prepare for a large scale emergency in the metropolitan area. Denver Health also participates in the Denver and Aurora metropolitan response system (MMRS), a collaboration that provides a regional planning framework to ensure comprehensive and coordinated planning among various response agencies.

The Pandemic Coordinator for University of Colorado Hospital discussed the hospital's pandemic and surge preparedness. The hospital has a stockpile of protective equipment, oxygen and intravenous supplies; however, the coordinator emphasized the need for training hospital personnel as well as training exercises across hospital systems in order to fully prepare for a large scale emergency. The emergency response system is complicated by regional command and control issues. The task force heard testimony expressing a need to develop alternative care sites as well as to continue pandemic planning and coordination with the state health department.

Blue Ribbon Commission for Health Care Reform

In 2006, the General Assembly commissioned a task force to evaluate major health care reform in Colorado. The 27-member commission, referred to as the Blue Ribbon Commission for Health Care Reform, or the 208 Commission, invited members of the public to submit proposals for comprehensive health care reform and it received 31 proposals. Out of the 31 proposals, the commission selected four for an in-depth 'modeling' analysis to evaluate the potential impacts on health care spending and coverage.

The 208 Commission members and the authors of the proposed health care reform plans provided information to the task force. The commission members provided an overview of the commission's charge, the methodology used to select the criteria for proposed health care reform, how the commission selected each proposal for further analysis, and the commission's activities. The authors of the selected proposals provided details on each proposal's design, coverage, and projected number of individuals covered under each plan. In addition to the four proposals presented, commission members prepared and presented a fifth proposal that is a compilation of elements from each of the four selected proposals, as well as other elements from the proposals.
that were not selected. The proposals selected by the 208 Commission are outlined in Table 1 — Comparing Selected Proposals for Comprehensive Health Care Reform in Colorado. The table indicates the name of the author of each plan and other corresponding proposal details.

Key elements of the five proposals include:

• combining Medicaid and the Child Health Plan Plus and expanding eligibility for these programs;
• requiring individuals to obtain health insurance and enforcing the requirement through a tax penalty;
• requiring employers to provide health insurance or pay an annual fee to the state if the employer would like to opt out of providing coverage;
• expanding subsidies for low-income individuals
• creating a 'connector' that serves as a single-point of entry for information, guidance, and education to help consumers make informed choices about the availability of health insurance options; and
• creating a single-payer program.

The commission will present a full report on the five proposals with highlights and recommendations to the House and Senate Health and Human Services committees on January 31, 2008.

Table 1
Comparing Selected Proposals for Comprehensive Health Care Reform in Colorado

<table>
<thead>
<tr>
<th>Proposal Author</th>
<th>Better Health Care for Colorado</th>
<th>A Plan for Covering Colorado</th>
<th>Solutions for Healthy Colorado</th>
<th>Colorado Health Services Program</th>
<th>208 Commission's Fifth Proposal</th>
</tr>
</thead>
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<tr>
<td><strong>Employer Mandate</strong></td>
<td>Service Employees International Union</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>*<strong>Individual Mandate</strong></td>
<td>Ad hoc committee of doctors and nurses</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Offers a Subsidy for Low-income Individuals</td>
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<td>✓</td>
<td>✓</td>
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<td>Less Comprehensive Benefits Package</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Purchasing Pool or Connector</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Insurance Market Reform</td>
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Table 1
Comparing Selected Proposals for Comprehensive Health Care Reform in Colorado (Cont.)

<table>
<thead>
<tr>
<th></th>
<th>Better Health Care for Colorado</th>
<th>A Plan for Covering Colorado</th>
<th>Solutions for Healthy Colorado</th>
<th>Colorado Health Services Program</th>
<th>208 Commission's Fifth Proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consolidate Insurance Market</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Expand Medicaid and CHP+</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Reform Medicaid and CHP+</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
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</tr>
<tr>
<td>Single-Payer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*</td>
</tr>
</tbody>
</table>

Source: Blue Ribbon Commission for Health Care Reform
*Contains elements of a single-payer system.
**Employer mandate means that employers would be required to provide health insurance to its employees or pay a fee.
***Individual mandate means that under the proposal, individuals would be required to obtain health insurance, otherwise face a tax penalty. Less comprehensive benefits package means a benefit packages, typically offered through a connector, that provides an annual maximum benefit of $35,000, versus other benefit packages that offer an annual maximum benefit of $50,000.

Health Information Technology

The task force discussed recent developments in health information technology including the use of electronic medical records and medication management. The task force observed the operating procedures for an electronic medical record system and heard about efforts to create a statewide network for the exchange of electronic health information.

Electronic medical records. Background information on electronic medical records and common record-keeping problems that could be remedied by utilizing electronic medical records were provided by representatives from Horizon Clinics. Estimates provided by Horizon Clinics show that, nationwide, 98,000 hospital patients a year die from medical errors, and 770,000 patients a year die from adverse drug events. In 81 percent of those cases, a patient's information was not available to an emergency room physician. Most health care transactions, including transferring patient records and filling prescriptions, are still conducted via mail, fax, or phone.

Colorado Clinical Guidelines, an organization that was started to address the increasing problems resulting from multiple entities disseminating clinical guidelines, demonstrated their medical records systems to the task force. Kaiser Permanente gave a live demonstration of KP Health Connect, the electronic medical records system at Kaiser. The system was created in the mid-1990s in cooperation with IBM. In 1998, the program was implemented in all of Kaiser’s facilities and Kaiser has been paperless ever since. The task force saw a typical patient record including what the patient sees via internet connection and what a physician sees on his or her end.
Regional health information organization. The task force talked about current programs that are being developed in an attempt to link the various electronic medical record systems. Members of the Colorado Regional Health Information Organization (CORHIO) explained their efforts to create a statewide network for the exchange of electronic health information, including links between an array of providers, organizations, and networks throughout the state, and eventually to other states as well. Eventually, CORHIO will position itself for interstate and nationwide health information exchange deployment. The four institutions that are part of building the prototype are Kaiser Permanente, Children's Hospital, University of Colorado Hospital, and Denver Health. A spokesperson from CORHIO used the advent of the ATM card as an analogy to demonstrate the collaboration that banks employed to achieve what they did with ATM card technology. Originally, ATM cards used to be proprietary to each bank and could only be used in specific machines. This actually hurt banks and eventually they realized the value of interoperability. The banking industry had to use collaborative efforts versus competition to move ahead, the same thing is true for health information technology.

Medication management. Representatives of retail pharmacies also talked to the task force about the benefits and the components of medication management through technology including the benefits of reviewing medication therapy with clients, maintaining personal medication records for historical reference, and upkeep of medication action plans. The Colorado Association of Homes and Services for the Aging and the Centers for Aging Services Technology illustrated current technologies that are being used to manage senior health including medication management and at-home check-ups through a computer.

Committee recommendation. As a result of these discussions, the task force recommends Bill A. The bill extends the Prescription Drug Information and Technical Assistance Program that was established in 2006 within the Department of Health Care Policy and Financing to provide advice about prescription drugs to Medicaid clients. The department administers the program and provides payments to pharmacists and physicians who consult with Medicaid clients about how to avoid dangerous drug interactions, improve outcomes, and save money. Bill A extends the program to include all programs administered by the DHCPF.

Other Health-related Issues

Throughout the interim, the task force touched on a number of other health-related issues including health disparities, provider shortages, cost drivers, and Medicaid pharmaceutical reimbursement.

Health disparities. The task force heard from the Office of Health Disparities, DPHE, about the office's responsibilities and were given an overview of the 2005 Racial and Ethnic Health Disparities in Colorado report. The report was written as a result of the office monitoring the health status of those with the highest levels of disease and death rates in the state, along with the medically underserved. The racial and ethnic health disparities of each racial group listed in the report were also discussed. The task force heard about the office's responsibility for administering and coordinating the Health Disparities Grant Program (HDGP) which provides financial support and technical assistance to nonprofit organizations and local public health agencies to address prevention, early detection, and treatment of cancer, cardiovascular disease, and pulmonary diseases in minority populations.
**Provider shortages.** Nursing and physician shortages in Colorado have increased in part because of issues such as increased utilization of health services; an increase in the diagnosis of chronic conditions, such as diabetes, asthma, and obesity; an increase in the aging population; and an increased life expectancy. The Colorado Health Institute and the Colorado Association of Family Medicine Residences discussed several possible ways to alleviate provider shortages including:

- the expansion of loan re-payment opportunities for physicians who commit to work in an underserved area;
- "Grow Your Own" programs in rural areas;
- putting a greater emphasis on Doctor of Osteopathic Medicine, or D.O., programs as opposed to Medical Doctor, or M.D. programs;
- expanding telemedicine;
- encouraging technology-driven training to increase productivity of existing medical staff; and
- examining the scope of practice issues to increase primary care capacity.

**Cost drivers.** The task force heard about cost drivers in health care from the Colorado Health Institute and the Colorado Hospital Association. Some of the cost drivers discussed were increasing costs of natural gas and petroleum products, the increased minimum wage, new technology costs coupled with consumer demand for new technology, legal issues associated with new technologies, cost shifting and the uninsured, and increasing pharmaceutical costs. Some possible solutions proposed were the utilization of electronic medical records and other technologies, evidence-based medicine, wellness programs, provider pay-for-performance programs, consumer directed health care, and disease management programs.

**Pharmaceutical reimbursement.** The task force heard concerns regarding proposed cuts for reimbursement of Medicaid prescription drugs. A new federal law will take effect in 2008 that will reduce the amount of pharmaceutical reimbursements for Medicaid prescriptions. The Colorado Retail Council provided some history of how pharmaceutical companies have done business in the past, and how costs continue to go up while reimbursement rates continue to drop.

**Committee recommendations.** As a result of this discussion, the task force is proposing Bill C which increases the dispensing fees paid to pharmacies for the remainder of FY 2007-08 to offset the reduction in the reimbursement rates. The task force also proposes Bill B, directing the DHCPF to seek a federal waiver to establish family planning services to categorically eligible individuals who are at or below an unspecified percentage of the federal poverty level. The percentage of the federal poverty level will be determined by the Centers for Medicaid and Medicare and the DHCPF.
Summary of Recommendations

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

Bill A — Expansion of the Prescription Drug Information and Technical Assistance Program

Bill A allows the Department of Health Care Policy and Financing to expand the Prescription Drug Information and Technical Assistance Program for Medicaid clients to include persons receiving drug benefits under any program that is administered by the department.

Bill B — Family Planning Pilot Program

In 1999, the Family Planning Pilot program was established to provide family planning services to individuals who are categorically eligible for Medicaid and are at or below 150 percent of the federal poverty level. The 1999 bill that was signed into law required the DHCPF to seek a federal waiver to implement the pilot program and stipulated that without a federal waiver the program could not be implemented. Although the Family Planning Pilot program was established, the DHCPF did not seek a federal waiver to implement the program. Bill B directs the DHCPF to seek a federal waiver to establish family planning services for categorically eligible individuals who are at or below a percentage of the federal poverty level. The bill does not specify a percentage of the federal poverty level, essentially removing the income limitations for eligibility. The percentage of the federal poverty level established in the federal waiver will be determined by the Centers for Medicaid and Medicare and the DHCPF.

Bill C — Change in Payments to Pharmacies for Certain Drugs Under Medicaid

Bill C requires the DHCPF to review and calculate the impact of a proposed reduction in reimbursement rates for dispensing Medicaid prescription drug scripts within 30 days of the implementation of changes to federal reimbursement rates. The proposed reduction in reimbursement rates are a result of the requirements in the federal "Deficit Reduction Act of 2005." The bill directs DHCPF to increase reimbursement for dispensing fees of Medicaid prescription drug scripts within 45 days of the implementation of changes in reimbursement rates by an amount that would approximate the difference in reimbursements paid to pharmacies for the remainder of the 2007-08 fiscal year.

Bill D — Emergency Medical Care Coverage in Connection with an Automobile Insurance Policy Issued in Colorado

Bill D requires all auto insurance policies issues, delivered, or renewed on or after January 1, 2009, in Colorado to include a minimum of $15,000 in emergency medical care coverage for all medically necessary and accident-related health care services within three years of the accident. The bill stipulated that any medically necessary and accident-related emergency medical care provided to a person claiming emergency medical care coverage by a first responder, trauma physician, trauma center, or emergency department of a licensed or certified hospital, must
be reimbursed at the rate of 200 percent of the 2006 Medicare Resource-based Relative Value Scale fee schedule. If an insurer fails to include emergency medical care coverage in an auto insurance policy, the minimum coverage amount is presumed to be provided by the insurer.

**Bill E — Funding for the Provision of Uncompensated Trauma Care to Persons Injured in Motor Vehicle Accidents in Colorado**

Bill E creates the Emergency Responders and Trauma Care Reimbursement Program and fund in the Department of Public Health and Environment. The fund will be used to provide reimbursement of uncompensated trauma care to ambulance companies, trauma physicians, and trauma centers for care of individuals injured in an auto accident. Money for the fund will be collected via an additional $16 vehicle registration fee beginning July 1, 2008. The bill further requires that all auto insurance policies written in Colorado include a minimum of $15,000 in emergency medical care coverage for all medically necessary and accident-related health care services. The bill makes emergency medical care coverage primary coverage for health care provided as a result of an auto accident. Finally, the bill requires the administrator of the program to provide an annual report to the House and Senate Health and Human Services committees that includes detailed information regarding:

- the total number of reimbursement applications received;
- the number and types of providers who apply for reimbursement;
- the total amount of reimbursement payments made;
- the recipients of reimbursement payments;
- the total amount of moneys credited to, and expended from, the fund;
- any balance remaining in the fund at the end of the fiscal year; the total amount of moneys recovered by the administrator from trauma patients or other parties;
- any recommendations for changes to the program; and
- any other information the program administrator deems appropriate or the committees request.
Resource Materials

Meeting summaries are prepared for each meeting of the committee and contain all handouts provided to the committee. The summaries of meetings and attachments are available at the Division of Archives, 1313 Sherman Street, Denver (303-866-2055). The listing below contains the dates of committee meetings and the topics discussed at those meetings. Meeting summaries are also available on our website at:

http://www.state.co.us/gov_dir/leg_dir/lcsstaff/2007/07interim.htm

Meeting Date and Topics Discussed

August 23, 2007
• Trauma care
• Emergency preparedness

September 10, 2007
• Overview of the 208 Commission activities
• Presentation of the proposed health care plan from the Colorado Health Services Program
• Presentation of the proposed health care plan from the Solutions for a Healthy Colorado
• Presentation of the proposed health care plan from the A Plan for Covering Colorado
• Presentation of the proposed health care plan from the Better Health Care for Colorado
• Discussion of health care disparities in Colorado from the Office of Health Disparities in the Department of Public Health and Environment
• Activities of the "Cover All Kids by 2010" Coalition
• Discussion of provider shortages and other cost drivers in Colorado

September 11, 2007
• Electronic medical records
• Medication management through technology
• Technology services for the aging
• Demonstrations of electronic medical records systems

October 9, 2007
• Physician and health plan collaboration
• Medicaid pharmaceutical reimbursement changes
• Proposals for possible legislation

Health Care Task Force
November 1, 2007

- Presentation of the fifth proposal for a new health care plan for the state
- Discussion and approval of proposed committee legislation
A BILL FOR AN ACT

CONCERNING THE EXPANSION OF THE PRESCRIPTION DRUG INFORMATION AND TECHNICAL ASSISTANCE PROGRAM TO INCLUDE PERSONS RECEIVING DRUG BENEFITS FROM ANY PROGRAM ADMINISTERED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

Bill Summary

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

Capital letters indicate new material to be added to existing statute. Dashes through the words indicate deletions from existing statute.
Health Care Task Force. Allows the department of health care policy and financing (department) to expand the prescription drug information and technical assistance program to include all programs administered by the department.

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

SECTION 1. Part 2 of article 1 of title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

25.5-1-203. Prescription drug information and technical assistance program - expansion. The state department may expand the prescription drug information and technical assistance program created in section 25.5-5-507, to include persons receiving drug benefits pursuant to any program that is administered by the state department.

SECTION 2. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety. <{ask committee}>
A BILL FOR AN ACT

CONCERNING ELIGIBILITY UNDER THE FAMILY PLANNING PILOT PROGRAM.

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 Task Force. Directs that the percentage of the federal poverty level used to determine eligibility for the family planning pilot program be established in the request for a federal waiver.

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

Capital letters indicate new material to be added to existing statute. Dashes through the words indicate deletions from existing statute.
SECTION 1. 25.5-5-319 (1), Colorado Revised Statutes, is amended to read:

25.5-5-319. Family planning pilot program - rules - federal waiver - repeal. (1) There is hereby established a family planning pilot program for the provision of family planning services to categorically eligible individuals who are at or below one hundred fifty percent of the federal poverty level established pursuant to the federal waiver sought pursuant to subsection (2) of this section. The state board shall promulgate rules setting forth the family planning services to be provided under the family planning pilot program.

SECTION 2. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety. <{Does the task force want a safety clause?}>
A BILL FOR AN ACT

CONCERNING A CHANGE IN THE DISPENSING FEE PAID TO PHARMACIES FOR CERTAIN DRUGS UNDER 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 Task Force. Directs the department of health care policy and financing to:

- Review the impact and calculate the anticipated reduction in the reimbursement rate to be paid to pharmacies due to the federal "Deficit Reduction Act of 2005"; and
- Submit an amendment to the state plan to increase the
dispensing fees paid to pharmacies for the remainder of the 2007-08 fiscal year for generic and nonpatented drugs to offset the reduction in the reimbursement rate.

Repeals the section, effective July 1, 2008.

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

SECTION 1. Part 5 of article 5 of title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

25.5-5-501.5. Generic drugs - dispensing fee - legislative declaration - repeal. (1) THE GENERAL ASSEMBLY HEREBY FINDS AND DECLARES THAT:

(a) THE FEDERAL "DEFICIT REDUCTION ACT OF 2005", PUB.L. 109-107, CHANGED THE CALCULATION OF THE FEDERAL UPPER PAYMENT LIMIT FOR GENERIC AND NONPATENTED DRUGS TO TWO HUNDRED FIFTY PERCENT OF THE AVERAGE MANUFACTURER PRICE.

(b) A DECEMBER 2006 GOVERNMENT ACCOUNTABILITY OFFICE REPORT FOUND THAT, ON AVERAGE, PHARMACIES WOULD BE PAID THIRTY-SIX PERCENT BELOW THEIR ACQUISITION COSTS USING THE NEW CALCULATION, THEREFORE FORCING PATIENTS TO SEEK SERVICES FROM EXPENSIVE EMERGENCY ROOMS AND DOCTORS' OFFICES.

(c) ALTHOUGH LEGISLATION IS PENDING IN CONGRESS TO DELAY THE EFFECTIVE DATE OR CHANGE THE CALCULATION OF THE FEDERAL UPPER PAYMENT LIMIT, RULES PROPOSED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES WOULD MAKE THE CHANGE IN THE CALCULATION EFFECTIVE DURING THE FIRST QUARTER OF 2008.

(d) WITHOUT OTHER CHANGES, IF THE CHANGE IN CALCULATING
THE FEDERAL UPPER PAYMENT LIMIT BECOMES EFFECTIVE, MANY LOCAL
PHARMACIES IN COLORADO WILL BE UNABLE TO FILL PRESCRIPTIONS FOR
MEDICAID RECIPIENTS AND MAY BE FORCED TO CLOSE.

(c) ONE WAY TO OFFSET THE REDUCTION IN THE PRICE
REIMBURSED FOR GENERIC AND NONPATENTED DRUGS IS FOR THE STATE
TO INCREASE THE DISPENSING FEE PAID TO PHARMACIES FOR FILLING
MEDICAID PRESCRIPTIONS.

(2) THE STATE DEPARTMENT SHALL REVIEW THE IMPACT OF THE
CHANGE IN THE CALCULATION OF THE FEDERAL UPPER PAYMENT LIMIT FOR
GENERIC AND NONPATENTED DRUGS REQUIRED BY THE "DEFICIT
REDUCTION ACT OF 2005" TO DETERMINE THE AMOUNT OF THE
REDUCTION FOR REIMBURSEMENT THAT PHARMACIES SHALL INURE
BECAUSE OF THE CHANGE AND THE AMOUNT THAT THE DISPENSING FEE
FOR GENERIC AND NONPATENTED DRUGS WOULD NEED TO BE INCREASED
TO OFFSET THIS REDUCTION. THE STATE DEPARTMENT SHALL SUBMIT TO
THE FEDERAL GOVERNMENT AN AMENDMENT TO THE STATE PLAN FOR
MEDICAL ASSISTANCE THAT SEEKS TO INCREASE THE DISPENSING FEE FOR
GENERIC AND NONPATENTED DRUGS STARTING ON THE EFFECTIVE DATE OF
ANY CHANGE IN THE REIMBURSEMENT RATE FOR THE REMAINDER OF THE
STATE FISCAL YEAR BEGINNING JULY 1, 2007, TO OFFSET THE REDUCTION
IN THE REIMBURSEMENT RATE FOR SUCH DRUGS. THE INCREASE IN THE
DISPENSING FEE REQUIRED BY THIS SUBSECTION (2) SHALL TAKE EFFECT
ONLY IF THE CHANGE IN THE CALCULATION OF THE FEDERAL UPPER
PAYMENT LIMIT REQUIRED BY THE "DEFICIT REDUCTION ACT OF 2005"
TAKES EFFECT.

(3) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2009.
SECTION 2. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety. \(<\text{Does the committee want a safety clause? To be effective during the 2007 fiscal year, the bill will require a safety clause.}>\)
A BILL FOR AN ACT

101 CONCERNING MEDICAL PAYMENTS COVERAGE IN CONNECTION WITH
102 AN AUTOMOBILE INSURANCE POLICY ISSUED IN COLORADO.

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 Task Force. Requires an automobile insurance policy issued, delivered, or renewed on or after January 1, 2009, to contain medical payments coverage of at least $15,000 to cover the costs of all medically necessary and accident-related health care services provided to a person injured in a motor vehicle accident within 3 years after the accident. Establishes a presumption that the minimum amount

Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.
and period of medical payments coverage required by law is included in an automobile insurance policy if the insurer fails to include any medical payments coverage in the policy. Preserves the right of the insurer to offer, and the insured to purchase, medical payments coverage in excess of the minimum coverage required by law.

Specifies to whom the medical payments coverage benefits are to be paid and the priority of payments to be made to providers for providing health care services to an injured person, requiring reimbursement first to first responders, hospitals, and trauma centers that provide emergency medical care. Specifies the method for determining the reimbursement rate for health care providers based on a percentage of the 2006 medicare resource-based relative value scale (RBRVS) fee schedule.

Preserves the right of the insured to choose his or her health care provider. Requires an insurer to honor a proper assignment of medical payments benefits by the insured to a health care provider and to promptly pay medical payments claims.

Modifies the disclosures required to be made to policyholders to clarify that, if an insured is also covered under a health insurance policy, the insured's medical payments coverage is primary to the health insurance coverage, will provide coverage before the health insurance coverage, and will apply to any coinsurance or deductible amounts required by the health insurance policy.

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

SECTION 1. 10-4-620, Colorado Revised Statutes, is amended to read:

10-4-620. Required coverages - legal liability - medical payments - definitions. (1) Subject to the limitations and exclusions authorized by this part 6, the basic coverage required for compliance with this part 6 is:

(a) Legal liability coverage for bodily injury or death arising out of the use of the motor vehicle to a limit, exclusive of interest and costs, of twenty-five thousand dollars to any one person in any one accident and fifty thousand dollars to all persons in any one accident and for property damage arising out of the use of the motor vehicle to a limit, exclusive of interest and costs, of fifteen thousand dollars in any one accident; AND

(b) (I) Medical payments coverage of at least fifteen
THOUSAND DOLLARS PER PERSON IN ANY ONE ACCIDENT FOR THE
PAYMENT OF ALL MEDICALLY NECESSARY AND ACCIDENT-RELATED
HEALTH CARE EXPENSES FOR BODILY INJURY ARISING OUT OF THE
OWNERSHIP, MAINTENANCE, OR USE OF THE MOTOR VEHICLE. PAYMENT
SHALL BE MADE TO A FIRST RESPONDER, LICENSED OR CERTIFIED HOSPITAL,
LICENSED HEALTH CARE PROVIDER AS DEFINED IN SECTION 10-4-902 (3),
MENTAL HEALTH CARE PROVIDER LICENSED OR REGULATED PURSUANT TO
ARTICLE 43 OF TITLE 12, C.R.S., OCCUPATIONAL THERAPIST AS DESCRIBED
IN SECTION 6-1-707 (1) (c), C.R.S., SPEECH THERAPIST, OR MASSAGE
THERAPIST AS DESCRIBED IN SECTION 12-48.5-103 (6), C.R.S., FOR
MEDICALLY NECESSARY AND ACCIDENT-RELATED HEALTH CARE SERVICES
PROVIDED TO THE INJURED PERSON WITHIN THREE YEARS AFTER THE
ACCIDENT.

(II) IF AN INSURER FAILS TO INCLUDE MEDICAL PAYMENTS
COVERAGE IN A POLICY ISSUED PURSUANT TO THIS PART 6, THE INSURED'S
POLICY SHALL BE PRESUMED TO INCLUDE THE MINIMUM MEDICAL
PAYMENTS COVERAGE REQUIRED BY THIS PARAGRAPH (b). NOTHING IN
THIS PARAGRAPH (b) SHALL PRECLUDE AN INSURER FROM OFFERING, OR AN
INSURED FROM PURCHASING, MEDICAL PAYMENTS COVERAGE IN EXCESS
OF THE AMOUNT OR FOR A LONGER PERIOD THAN THE AMOUNT OR PERIOD
OF COVERAGE REQUIRED BY THIS PARAGRAPH (b).

(III) THE MEDICAL PAYMENTS COVERAGE BENEFITS REQUIRED BY
THIS PARAGRAPH (b) SHALL BE PAID TO PERSONS OR ENTITIES PROVIDING
MEDICALLY NECESSARY AND ACCIDENT-RELATED HEALTH CARE SERVICES
IN THE FOLLOWING ORDER OF PRIORITY:

(A) BENEFITS SHALL FIRST BE PAID TO FIRST RESPONDERS AND TO
A HOSPITAL OR TRAUMA CENTER WHOSE EMERGENCY DEPARTMENT
PHYSICIANS AND STAFF OR TRAUMA SERVICE CALL PANEL PHYSICIANS AND
STAFF PROVIDE CARE IMMEDIATELY AFTER A MOTOR VEHICLE ACCIDENT.
(B) Any remaining benefits shall be paid to providers described in subparagraph (I) of this paragraph (b) who provide subsequent health care services.

(IV) Except as provided in subparagraph (V) of this paragraph (b), medically necessary and accident-related health care provided to a person claiming medical payments coverage shall be reimbursed as follows:

(A) For expenses related to services provided by providers described in sub-subparagraph (A) of subparagraph (III) of this paragraph (b), two hundred percent of the 2006 Medicare resource-based relative value scale (RBRVS) fee schedule, adjusted by the geographical practice cost index, or a successor index; and

(B) For expenses related to services provided by providers described in sub-subparagraph (B) of subparagraph (III) of this paragraph (b), one hundred fifty percent of the 2006 Medicare RBRVS fee schedule, adjusted by the geographical practice cost index, or a successor index.

(V) Nothing in this paragraph (b) shall limit the ability of an injured person to choose or change his or her health care provider.

(VI) An insurer shall honor a proper assignment of medical payments coverage benefits made pursuant to section 10-4-634 and shall promptly pay claims for medical payments coverage in accordance with section 10-4-642.

(VII) As used in this paragraph (b), unless the context otherwise requires:

(A) "First responder" means a person or entity that responds to, and provides emergency medical care to an
INDIVIDUAL INJURED IN A MOTOR VEHICLE ACCIDENT. THE TERM INCLUDES, BUT IS NOT LIMITED TO, A PERSON OR ENTITY PROVIDING AMBULANCE SERVICE, INCLUDING AIR AMBULANCE SERVICE, AN EMERGENCY MEDICAL TECHNICIAN, AS DEFINED IN SECTION 25-3.5-103 (8), C.R.S., AND ANY SERVICE AGENCY, AS DEFINED IN SECTION 25-3.5-103 (11.5), C.R.S., OR OTHER PERSON OR ENTITY THAT PROVIDES EMERGENCY MEDICAL CARE AT THE SCENE OF OR IMMEDIATELY AFTER A MOTOR VEHICLE ACCIDENT. "FIRST RESPONDER" DOES NOT INCLUDE A HOSPITAL.

(B) "MEDICALLY NECESSARY" HEALTH CARE SERVICES OR PRODUCTS ARE THOSE SERVICES OR PRODUCTS THAT ARE PROVIDED BY A PROVIDER DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH (b) TO A PERSON INJURED IN A MOTOR VEHICLE ACCIDENT AND THAT ARE REQUIRED TO IDENTIFY, DIAGNOSE, TREAT, REHABILITATE, OR AMELIORATE THE PERSON'S INJURY, ITS EFFECTS, OR THE SYMPTOMS OF THE INJURY IN A MANNER THAT IS CONSISTENT WITH GENERALLY ACCEPTED STANDARDS OF THE PROVIDER'S HEALTH CARE PROFESSION; CLINICALLY APPROPRIATE IN TERMS OF TYPE, FREQUENCY, EXTENT, TIMING, SITE, AND DURATION; REPRESENTATIVE OF THE BEST PRACTICES OF THE PROFESSION OR OF TREATMENT PRACTICE GUIDELINES OR ETHICS ADOPTED, RECOGNIZED, OR GENERALLY ACCEPTED BY STATE OR NATIONAL PROFESSIONAL ASSOCIATIONS FOR THE RESPECTIVE HEALTH CARE PROFESSION; OR EFFICIENT IN A MANNER TO AVOID WASTE AND REFRAIN FROM THE PROVISION OF SERVICES THAT ARE NOT LIKELY TO PRODUCE BENEFIT TO OR ARE NOT PRIMARILY FOR THE CONVENIENCE OF THE INJURED PERSON OR HEALTH CARE PROVIDER.

(2) NOTHING IN THIS SECTION SHALL BE CONSTRUED TO LIMIT ANY OTHER COVERAGE AMOUNTS MADE AVAILABLE BY AN INSURER.

SECTION 2. Repeal. 10-4-635 (1), Colorado Revised Statutes, is repealed as follows:
10-4-635. Medical payments coverage - no tort recovery.

(1) If an insurer makes available medical payments coverage in conjunction with the coverage required pursuant to section 10-4-620, such medical payments coverage shall provide for benefits of five thousand dollars, as well as any other benefit deemed appropriate by the insurer. Nothing in this section shall be construed to limit any other coverage amounts being made available by an insurer.

SECTION 3. 10-4-636 (4) (b), Colorado Revised Statutes, is amended to read:

10-4-636. Disclosure requirements for automobile insurance products offered - rules. (4) The disclosure form required by subsection (1) of this section shall include a disclosure specifying that:

(b) If the insured also has health insurance coverage, the medical payments coverage:

(I) Is primary to any health insurance coverage available to the insured when injured in a motor vehicle accident;

(II) Shall provide coverage before the health insurance coverage; and

(III) Shall apply to any coinsurance or deductible amount required by the health insurance coverage plan or policy;

SECTION 4. Effective date - applicability. This act shall take effect January 1, 2009, and shall apply to automobile insurance policies issued, delivered, or renewed 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. ASK COMMITTEE
A BILL FOR AN ACT

CONCERNING FUNDING FOR THE PROVISION OF UNCOMPENSATED TRAUMA CARE TO PERSONS INJURED IN MOTOR VEHICLE ACCIDENTS IN COLORADO, AND, IN CONNECTION THEREWITH, ESTABLISHING AN EMERGENCY RESPONDERS AND TRAUMA CARE REIMBURSEMENT PROGRAM, INCREASING THE FEE FOR REGISTERING A MOTOR VEHICLE TO FUND THE PROGRAM, AND REQUIRING AUTOMOBILE INSURANCE POLICIES ISSUED IN THE STATE TO CONTAIN EMERGENCY MEDICAL CARE COVERAGE.

Bill Summary

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

Capital letters indicate new material to be added to existing statute. Dashes through the words indicate deletions from existing statute.)
Health Care Task Force. Establishes the emergency responders and trauma care reimbursement program in the department of public health and environment (department) to reimburse emergency and trauma care providers for uncompensated care provided to patients injured in a motor vehicle accident. Allows reimbursements for uncompensated trauma care to licensed ambulances, licensed air ambulances, trauma physicians, and trauma centers that satisfy specified criteria, and prioritizes reimbursement payments first to the ambulances, then to the physicians, and last to the trauma centers.

Requires the executive director of the department to identify an entity to administer the program (program administrator). Outlines the duties of the program administrator, including:

- Starting the program by July 1, 2009;
- Reimbursing providers for uncompensated trauma care in a timely and efficient manner;
- Managing the administrative costs of the program;
- Seeking payment from other responsible parties to reimburse the emergency responders and trauma care reimbursement fund (program fund);
- Establishing criteria and qualifications that an applicant must meet to obtain reimbursement from the program fund, including a requirement that the applicant attempt to collect payment for trauma care from the trauma patient or other responsible party;
- Determining the types and amount of costs of uncompensated care for which reimbursement will be allowed and the maximum dollar amount of allowable reimbursement.

Establishes the program fund in the state treasury, consisting of moneys credited to the program fund from a $16 fee on motor vehicle registrations and moneys recovered from responsible parties for the payment of trauma care that was reimbursed by the program fund. Caps the amount of moneys in the program fund that may be used to administer the program and requires the remainder of the program fund to be used to reimburse trauma care providers for uncompensated trauma care.

Requires the program administrator to submit an annual report to the health and human services committees of the senate and house of representatives and details the information to be included in the report.

Mandates all automobile insurance policies issued, delivered, or renewed in the state to contain emergency medical care coverage with benefits of at least $15,000.

Increases the fee for registering a motor vehicle, other than a fleet vehicle, by $16 and directs that the moneys from the increased fee be transferred to the program fund.
Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Article 3.5 of title 25, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PART to read:

PART 9
EMERGENCY RESPONDERS AND TRAUMA CARE REIMBURSEMENT PROGRAM

25-3.5-901. Definitions. As used in this Part 9, unless the context otherwise requires:

(1) "Fund" means the Emergency Responders and Trauma Care Reimbursement Fund created in section 25-3.5-903.

(2) "Licensed air ambulance" means an air ambulance, as defined in section 25-3.5-103 (1), that is licensed by the department pursuant to section 25-3.5-307.

(3) "Licensed ambulance" means an ambulance, as defined in section 25-3.5-103 (1.5), that is licensed pursuant to section 25-3.5-301.

(4) "Program" means the Emergency Responders and Trauma Care Reimbursement Program created in section 25-3.5-902 (1).

(5) "Program administrator" means the entity selected by the director pursuant to section 25-3.5-902 (2) to administer the program.

(6) "Provider" means a licensed ambulance, licensed air ambulance, trauma physician, or trauma center that provides trauma care to a trauma patient injured in a motor vehicle accident.
(7) "Stabilize" means, with respect to a medical condition resulting from a trauma, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during the transfer of the individual to or from a trauma center.

(8) "Trauma" means an injury or wound to a living person caused by the application of an external physical force. Trauma includes any event that threatens life, limb, or the well-being of an individual in such a manner that a prudent lay person would believe that immediate medical care is needed.

(9) "Trauma care" or "emergency medical care" means care provided by a licensed ambulance or air ambulance, trauma physician, or trauma center to a trauma patient injured in a motor vehicle accident from the time the administration of care begins to the time the patient is fully stabilized or through the first episode of care, not to exceed seventy-two hours after the administration of care begins. The term includes a trauma care system, trauma transport protocols, and triage, as defined in section 25-3.5-703 (10), (11), and (12), respectively.

(10) "Trauma center" means a health care facility or an emergency department in a licensed or certified hospital that is designated by the department as a level I, II, III, IV, or V facility, or a health care facility designated by the department as a regional pediatric trauma center.

(11) "Trauma physician" means a trauma surgeon, orthopedic surgeon, neurosurgeon, intensive care unit physician,
ANESTHESIOLOGIST, OR PHYSICIAN WHO PROVIDES CARE IN A TRAUMA CENTER TO A TRAUMA PATIENT INJURED IN A MOTOR VEHICLE ACCIDENT.

(12) "Uncompensated trauma care" means trauma care provided by a licensed ambulance or air ambulance, trauma physician, or trauma center to a trauma patient who has not paid for the trauma care after documented attempts by the provider to collect payment owed by the patient and who:

(a) (I) Has copayment or deductible health insurance responsibility; or

(II) Does not have health insurance coverage or Medicare coverage or does not have any or a sufficient amount of medical payments coverage under an automobile insurance policy; and

(b) Is not eligible for coverage under the "Colorado Medical Assistance Act", article 4 of title 25.5, C.R.S.

25-3.5-902. Emergency responders and trauma care reimbursement program - creation - administration. (1) There is hereby established, in the department, the emergency responders and trauma care reimbursement program, also referred to in this section as the "program". The purpose of the program shall be to provide reimbursement of uncompensated trauma care provided by a licensed ambulance or air ambulance, trauma physician, or trauma center to a trauma patient injured in a motor vehicle accident that occurs within the state of Colorado.

(2) (a) By January 1, 2009, the director shall identify an entity to administer the program, based on information indicating which entity has the ability to administer the
PROGRAM IN THE MOST EFFECTIVE AND EFFICIENT MANNER. THE DIRECTOR SHALL TAKE INTO CONSIDERATION THE ABILITY OF THE ENTITY TO:

(I) START THE PROGRAM NO LATER THAN JULY 1, 2009;
(II) ADMINISTER THE PROGRAM AND REIMBURSE PROVIDERS FOR UNCOMPENSATED TRAUMA CARE IN A TIMELY AND EFFICIENT MANNER;
(III) MANAGE THE COSTS OF THE PROGRAM; AND
(IV) SEEK PAYMENT FROM OTHER RESPONSIBLE PARTIES FOR COSTS REIMBURSED FROM THE FUND AND SUBROGATE TO THE RIGHTS OF THE PROVIDERS WHO OBTAIN REIMBURSEMENT PAYMENTS FROM THE FUND.

(b) USING THE INFORMATION OUTLINED IN PARAGRAPH (a) OF THIS SUBSECTION (2), THE DIRECTOR MAY SELECT ONE OF THE FOLLOWING ENTITIES TO ADMINISTER THE PROGRAM:

(I) THE STATE DEPARTMENT, DIVISION, OR AGENCY BEST ABLE TO ADMINISTER THE PROGRAM;
(II) THE BOARD OF DIRECTORS OF A POLITICAL SUBDIVISION OF THE STATE OPERATING AS A DOMESTIC MUTUAL INSURANCE COMPANY; OR
(III) A PRIVATE CONTRACTOR SELECTED BY THE DIRECTOR PURSUANT TO A REQUEST FOR PROPOSAL PROCESS.

(c) ONCE THE PROGRAM ADMINISTRATOR HAS BEEN SELECTED, THE DIRECTOR SHALL NOTIFY THE HEALTH AND HUMAN SERVICES COMMITTEES OF THE SENATE AND THE HOUSE OF REPRESENTATIVES, OR ANY SUCCESSOR COMMITTEES, OF THE DIRECTOR'S SELECTION.

(d) THE PROGRAM ADMINISTRATOR SHALL MAKE EVERY EFFORT TO START THE PROGRAM AS SOON AS POSSIBLE AFTER THE DIRECTOR MAKES HIS OR HER SELECTION PURSUANT TO THIS SUBSECTION (2), BUT IN NO
EVENT SHALL THE PROGRAM BE STARTED LATER THAN JULY 1, 2009.

(3) (a) ON AND AFTER THE DATE DETERMINED BY THE PROGRAM ADMINISTRATOR, BUT NOT LATER THAN JULY 1, 2009, A LICENSED AMBULANCE OR AIR AMBULANCE, TRAUMA PHYSICIAN, OR TRAUMA CENTER THAT HAS PROVIDED UNCOMPENSATED TRAUMA CARE ON OR AFTER JANUARY 1, 2009, MAY APPLY FOR REIMBURSEMENT FROM THE FUND IN THE FORM AND MANNER REQUIRED BY THE PROGRAM ADMINISTRATOR. AS PART OF THE APPLICATION FOR REIMBURSEMENT, AN APPLICANT SHALL DOCUMENT THE APPLICANT'S ATTEMPTS TO COLLECT PAYMENT FROM THE TRAUMA PATIENT OR ANY OTHER PERSON OR ENTITY THAT MAY BE RESPONSIBLE FOR PAYMENT OF THE UNCOMPENSATED TRAUMA CARE PROVIDED TO THE TRAUMA PATIENT.

(b) THE PROGRAM ADMINISTRATOR SHALL ESTABLISH CRITERIA AND QUALIFICATIONS THAT AN APPLICANT SHALL SATISFY IN ORDER TO BE ELIGIBLE FOR REIMBURSEMENT FROM THE FUND. THE CRITERIA AND QUALIFICATIONS SHALL INCLUDE, BUT NEED NOT BE LIMITED TO, THE FOLLOWING:

(I) THAT THE APPLICANT HAS MADE ATTEMPTS TO COLLECT PAYMENT FROM THE TRAUMA PATIENT OR OTHER RESPONSIBLE PARTY FOR A PERIOD DETERMINED BY THE PROGRAM ADMINISTRATOR, NOT TO EXCEED SIX MONTHS, PRIOR TO FILING A REIMBURSEMENT APPLICATION;

(II) THAT THE APPLICANT IS EITHER A LICENSED AMBULANCE OR AIR AMBULANCE, TRAUMA PHYSICIAN, OR TRAUMA CENTER THAT HAS PROVIDED UNCOMPENSATED TRAUMA CARE ON OR AFTER JANUARY 1, 2009, TO A TRAUMA PATIENT INJURED IN A MOTOR VEHICLE ACCIDENT THAT OCCURRED WITHIN THE STATE OF COLORADO;

(III) THAT THE APPLICANT HAS PROVIDED DOCUMENTATION OF THE

(IV) THAT THE APPLICANT WILL ALLOW THE PROGRAM ADMINISTRATOR TO BE SUBROGATED TO THE RIGHTS OF THE APPLICANT TO ANY CLAIM FOR PAYMENT AGAINST THE TRAUMA PATIENT OR OTHER PARTY RESPONSIBLE FOR PAYMENT OF THE TRAUMA CARE, AND THAT THE APPLICANT WILL COOPERATE WITH THE PROGRAM ADMINISTRATOR TO COLLECT THE AMOUNT PAID TO THE APPLICANT FROM ANY THIRD PARTY.

(c) THE PROGRAM ADMINISTRATOR SHALL DETERMINE THE TYPES AND AMOUNT OF COSTS OF UNCOMPENSATED TRAUMA CARE FOR WHICH APPLICANTS MAY RECEIVE REIMBURSEMENT AND THE MAXIMUM AMOUNT OF ALLOWABLE REIMBURSEMENT FOR THE UNCOMPENSATED TRAUMA CARE.

(d) (I) THE PROGRAM ADMINISTRATOR SHALL REVIEW ALL APPLICATIONS FOR REIMBURSEMENT TO ENSURE COMPLIANCE WITH THE CRITERIA AND QUALIFICATIONS AND SHALL PRIORITIZE APPLICATIONS AS FOLLOWS:

(A) APPLICATIONS SUBMITTED BY LICENSED AMBULANCES OR AIR AMBULANCES THAT PROVIDE UNCOMPENSATED TRAUMA CARE AT THE SCENE OF OR IMMEDIATELY AFTER THE MOTOR VEHICLE ACCIDENT, INCLUDING TRANSPORT TO OR FROM A TRAUMA CENTER, SHALL RECEIVE FIRST PRIORITY.

(B) APPLICATIONS SUBMITTED BY TRAUMA PHYSICIANS THAT PROVIDE UNCOMPENSATED TRAUMA CARE TO STABILIZE OR PROVIDE THE FIRST EPISODE OF CARE TO THE TRAUMA PATIENT SHALL RECEIVE SECOND
PRIORITY.

(C) APPLICATIONS SUBMITTED BY TRAUMA CENTERS DESIGNATED AS LEVEL I, II, III, IV, OR V PURSUANT TO SECTION 25-3.5-703 (4), INCLUDING TRAUMA CENTERS LOCATED IN RURAL PARTS OF THE STATE, THAT PROVIDE UNCOMPENSATED TRAUMA CARE TO STABILIZE OR PROVIDE THE FIRST EPISODE OF CARE TO THE TRAUMA PATIENT SHALL RECEIVE THIRD PRIORITY.

(II) THE PROGRAM ADMINISTRATOR SHALL FIRST MAKE REIMBURSEMENT PAYMENTS TO APPLICANTS WHO HAVE FIRST PRIORITY. IF THE BALANCE IN THE FUND IS INSUFFICIENT TO FULLY REIMBURSE ALL FIRST-PRIORITY APPLICANTS, THE PROGRAM ADMINISTRATOR SHALL DETERMINE A MECHANISM FOR MAKING THE REIMBURSEMENT PAYMENTS TO THE QUALIFIED FIRST-PRIORITY APPLICANTS IN AN EQUITABLE MANNER.

(III) IF THE BALANCE IN THE FUND IS SUFFICIENT TO FULLY REIMBURSE ALL QUALIFIED FIRST-PRIORITY APPLICANTS, THE PROGRAM ADMINISTRATOR SHALL USE THE REMAINING AVAILABLE BALANCE IN THE FUND TO MAKE REIMBURSEMENT PAYMENTS TO QUALIFIED SECOND-PRIORITY APPLICANTS IN THE MANNER SET FORTH IN SUBPARAGRAPH (II) OF THIS PARAGRAPH (d).

(IV) IF THE BALANCE IN THE FUND IS SUFFICIENT TO FULLY REIMBURSE ALL QUALIFIED FIRST- AND SECOND-PRIORITY APPLICANTS, THE PROGRAM ADMINISTRATOR SHALL USE THE REMAINING AVAILABLE BALANCE IN THE FUND TO MAKE REIMBURSEMENT PAYMENTS TO QUALIFIED THIRD-PRIORITY APPLICANTS IN THE MANNER SET FORTH IN SUBPARAGRAPH (II) OF THIS PARAGRAPH (d).

(e) THE PROGRAM ADMINISTRATOR SHALL MAKE REIMBURSEMENT PAYMENTS FROM THE FUND TO QUALIFIED APPLICANTS AT LEAST
Annually or more frequently as determined appropriate by the program administrator. The program administrator shall establish deadlines within which applicants shall file reimbursement applications.

25-3.5-903. Emergency responders and trauma care reimbursement fund - creation - use. (1) There is hereby established in the state treasury the emergency responders and trauma care reimbursement fund. The fund shall consist of all moneys credited thereto in accordance with section 42-3-304 (25), C.R.S., and any moneys recovered by the administrator from trauma patients or other parties responsible for the payment of trauma care that was reimbursed by the fund. All interest earned on the investment of moneys in the fund shall be credited to the fund. The moneys in the fund are hereby continuously appropriated for the purposes set forth in this section. Any moneys credited to the fund and unexpended at the end of any given fiscal year shall remain in the fund and shall not revert to the general fund or any other fund.

(2) Of the moneys in the fund, not more than three percent shall be used for program administrative costs, including the administrative costs of the division and of the entity selected as the program administrator.

(3) The moneys remaining in the fund after the payment of administrative costs shall be used to provide reimbursement to licensed ambulance and air ambulances, trauma physicians, and trauma centers for uncompensated trauma care as specified in section 25-3.5-902.
25-3.5-904. Annual report. (1) By January 1, 2012, and each January 1 thereafter, the program administrator shall submit an annual report to the Health and Human Services Committees of the Senate and the House of Representatives, or any successor committees, regarding the program. The report shall include detailed information regarding:

(a) The total number of reimbursement applications received since the start of the program and the number of applications received each year;

(b) The number and types of providers who apply for reimbursement;

(c) The total amount of reimbursement payments made since the start of the program, specifying the amounts paid each year;

(d) The recipients of reimbursement payments, including the type of provider, the number of reimbursement applications made by each recipient, the amount of each reimbursement made to each recipient, and the total amount requested by and paid to each recipient;

(e) For each year since the program started, the total amount of moneys credited to and expended from the fund, the total dollar amounts of all payment requests, the total dollar amounts expended from the fund for reimbursement payments, and the administrative expenses of the program;

(f) Any balance remaining in the fund at the end of the fiscal year, the amount reimbursed to the fund through subrogation, an explanation of the outstanding fund balance,
REVENUES PROJECTED TO BE DEPOSITED INTO THE FUND IN THE NEXT FIVE FISCAL YEARS, AND THE ESTIMATED REIMBURSEMENT NEEDS FOR THE NEXT FIVE FISCAL YEARS;

(g) THE TOTAL AMOUNT OF MONEYS RECOVERED BY THE ADMINISTRATOR FROM TRAUMA PATIENTS OR OTHER PARTIES RESPONSIBLE FOR THE PAYMENT OF TRAUMA CARE THAT WAS REIMBURSED BY THE FUND, EACH YEAR SINCE THE PROGRAM STARTED;

(h) ANY RECOMMENDATIONS THE PROGRAM ADMINISTRATOR MAY HAVE REGARDING CHANGES TO THE PROGRAM OR MODIFICATIONS TO THE AMOUNT OF THE FEE COLLECTED PURSUANT TO SECTION 42-3-304 (25), C.R.S.; AND

(i) ANY OTHER INFORMATION THE PROGRAM ADMINISTRATOR DEEMS APPROPRIATE OR THAT THE HEALTH AND HUMAN SERVICES COMMITTEES REQUEST.

SECTION 2. 10-4-620, Colorado Revised Statutes, is amended to read:

10-4-620. Required coverage - definitions. (1) Subject to the limitations and exclusions authorized by this part 6, the basic coverage required for compliance with this part 6 is:

(a) Legal liability coverage for bodily injury or death arising out of the use of the motor vehicle to a limit, exclusive of interest and costs, of twenty-five thousand dollars to any one person in any one accident and fifty thousand dollars to all persons in any one accident and for property damage arising out of the use of the motor vehicle to a limit, exclusive of interest and costs, of fifteen thousand dollars in any one accident; AND

(b) (I) EMERGENCY MEDICAL CARE COVERAGE FOR BODILY INJURY ARISING OUT OF THE USE OF THE MOTOR VEHICLE WITH BENEFITS OF AT
LEAST FIFTEEN THOUSAND DOLLARS FOR ALL REASONABLE, NECESSARY, AND ACCIDENT-RELATED EMERGENCY MEDICAL CARE PROVIDED TO AN INJURED PERSON BY A LICENSED AMBULANCE OR AIR AMBULANCE, TRAUMA PHYSICIAN, OR TRAUMA CENTER AT THE SCENE OF OR IMMEDIATELY AFTER A MOTOR VEHICLE ACCIDENT. IF THE INJURED PERSON FOR WHOM EMERGENCY MEDICAL CARE COVERAGE IS PAID IS FOUND NOT AT FAULT IN THE ACCIDENT, THE INSURER THAT PAID THE COVERAGE SHALL BE SUBROGATED TO THE RIGHTS OF THE INJURED PERSON AGAINST THE AT-FAULT PERSON, TO THE EXTENT OF THE PAYMENTS MADE, AFTER THE INJURED PERSON IS FULLY COMPENSATED FOR INJURIES SUSTAINED IN THE ACCIDENT.

(II) EMERGENCY MEDICAL CARE COVERAGE SHALL BE PRIMARY TO ANY HEALTH INSURANCE BENEFITS OF, OR PUBLIC HEALTH BENEFITS AVAILABLE TO, A PERSON INJURED IN A MOTOR VEHICLE ACCIDENT AND SHALL APPLY TO ANY COINSURANCE OR DEDUCTIBLE AMOUNT REQUIRED BY THE INJURED PERSON'S HEALTH COVERAGE PLAN, AS DEFINED IN SECTION 10-16-102 (22.5).

(III) AS USED IN THIS PARAGRAPH (b):

(A) "EMERGENCY MEDICAL CARE" OR "TRAUMA CARE" MEANS CARE PROVIDED BY A LICENSED AMBULANCE OR AIR AMBULANCE, TRAUMA PHYSICIAN, OR TRAUMA CENTER TO A TRAUMA PATIENT INJURED IN A MOTOR VEHICLE ACCIDENT FROM THE TIME THE ADMINISTRATION OF CARE BEGINS TO THE TIME THE PATIENT IS FULLY STABILIZED OR THROUGH THE FIRST EPISODE OF CARE, NOT TO EXCEED SEVENTY-TWO HOURS AFTER THE ADMINISTRATION OF CARE BEGINS. THE TERM INCLUDES A TRAUMA CARE SYSTEM, TRAUMA TRANSPORT PROTOCOLS, AND TRIAGE, AS DEFINED IN SECTION 25-3.5-703 (10), (11), AND (12), RESPECTIVELY.
(B) "INJURED PERSON" MEANS THE INSURED, OR A PASSENGER WHO
IS AUTHORIZED BY THE INSURED TO OCCUPY THE INSURED'S MOTOR
VEHICLE, WHO SUSTAINS BODILY INJURY ARISING OUT OF THE USE OF THE
INSURED'S MOTOR VEHICLE.

(C) "LICENSED AIR AMBULANCE" MEANS AN AIR AMBULANCE, AS
DEFINED IN SECTION 25-3.5-103 (1), C.R.S., THAT IS LICENSED BY THE
DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT PURSUANT TO
SECTION 25-3.5-307, C.R.S.

(D) "LICENSED AMBULANCE" MEANS AN AMBULANCE, AS DEFINED
IN SECTION 25-3.5-103 (1.5), C.R.S., THAT IS LICENSED PURSUANT TO
SECTION 25-3.5-301, C.R.S.

(E) "STABILIZE" MEANS, WITH RESPECT TO A MEDICAL CONDITION
RESULTING FROM A TRAUMA, TO PROVIDE SUCH MEDICAL TREATMENT OF
THE CONDITION AS MAY BE NECESSARY TO ASSURE, WITHIN REASONABLE
MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION OF THE
CONDITION IS LIKELY TO RESULT OR OCCUR DURING THE TRANSFER OF THE
INDIVIDUAL TO OR FROM A TRAUMA CENTER.

(F) "TRAUMA" MEANS AN INJURY OR WOUND TO A LIVING PERSON
CAUSED BY THE APPLICATION OF AN EXTERNAL PHYSICAL FORCE. TRAUMA
INCLUDES ANY EVENT THAT THREATENS LIFE, LIMB, OR THE WELL-BEING
OF AN INDIVIDUAL IN SUCH A MANNER THAT A PRUDENT LAY PERSON
WOULD BELIEVE THAT IMMEDIATE MEDICAL CARE IS NEEDED.

(G) "TRAUMA CENTER" MEANS A HEALTH CARE FACILITY OR AN
EMERGENCY DEPARTMENT IN A LICENSED OR CERTIFIED HOSPITAL THAT IS
DESIGNATED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
AS A LEVEL I, II, III, IV, OR V FACILITY, OR A HEALTH CARE FACILITY
DESIGNATED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
AS A REGIONAL PEDIATRIC TRAUMA CENTER.

(H) "TRAUMA PHYSICIAN" MEANS A TRAUMA SURGEON, ORTHOPEDIC SURGEON, NEUROSURGEON, INTENSIVE CARE UNIT PHYSICIAN, ANESTHESIOLOGIST, OR PHYSICIAN WHO PROVIDES CARE IN A TRAUMA CENTER TO A TRAUMA PATIENT INJURED IN A MOTOR VEHICLE ACCIDENT.

SECTION 3. 42-3-304, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

42-3-304. Registration fees - passenger and passenger-mile taxes - clean screen fund - repeal. (25) (a) IN ORDER TO PROVIDE FUNDING FOR EMERGENCY MEDICAL CARE NECESSITATED BY THE OCCURRENCE OF MOTOR VEHICLE ACCIDENTS ON HIGHWAYS THROUGHOUT THE STATE, IN ADDITION TO ANY OTHER FEES IMPOSED BY THIS SECTION, ON AND AFTER JULY 1, 2008, THERE SHALL BE ASSESSED AN ADDITIONAL FEE OF SIXTEEN DOLLARS AT THE TIME OF REGISTRATION OF ANY MOTOR VEHICLE EXCEPT A FLEET VEHICLE. THE FEE SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT THE SAME TO THE EMERGENCY RESPONDERS AND TRAUMA CARE REIMBURSEMENT FUND CREATED IN SECTION 25-3.5-903, C.R.S.

(b) NOTWITHSTANDING THE AMOUNT SPECIFIED FOR THE FEE IN PARAGRAPH (a) OF THIS SUBSECTION (25), THE DIRECTOR BY RULE OR AS OTHERWISE PROVIDED BY LAW MAY REDUCE THE AMOUNT OF THE FEE IF NECESSARY PURSUANT TO SECTION 24-75-402 (3), C.R.S., TO REDUCE THE UNCOMMITTED RESERVES OF THE EMERGENCY RESPONDERS AND TRAUMA CARE REIMBURSEMENT FUND CREATED IN SECTION 25-3.5-903, C.R.S. AFTER THE UNCOMMITTED RESERVES OF THE FUND ARE SUFFICIENTLY REDUCED, THE DIRECTOR BY RULE OR AS OTHERWISE PROVIDED BY LAW MAY INCREASE THE AMOUNT OF THE FEE AS PROVIDED IN SECTION
SECTION 4. Effective date - applicability. (1) Except as provided in subsection (2) of this section, this act shall take effect upon passage.

(2) Section 2 of this act shall take effect January 1, 2009, and shall apply to automobile insurance policies issued, delivered, or renewed 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.