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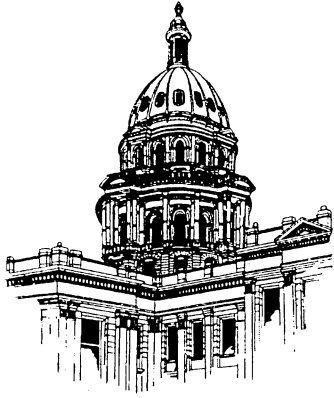
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## 0568 Health Care Task Force



**Report to the  
Colorado General Assembly**

**Health Care Task Force**

*The Colorado Legislative Council  
Research Publication No. 568  
December 2007*

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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

Representative Edward Casso  
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Representative Tom Massey  
Representative Spencer Swalm

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*This report is also available on line 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**

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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.<sup>1</sup> The task force must meet at least four times each year, and continues until July 1, 2010.

### **Committee Activities**

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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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<sup>1</sup>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 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. 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**

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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.



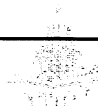
## Committee Charge

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.



## 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

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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**

	Better Health Care for Colorado	A Plan for Covering Colorado	Solutions for Healthy Colorado	Colorado Health Services Program	208 Commission's Fifth Proposal
Proposal Author	Service Employees International Union	Ad hoc committee of doctors and nurses	Colorado State Association of Health Underwriters	Doctors and nurses supporting a single-payer system	208 Commissioners
**Employer Mandate		✓		✓	
***Individual Mandate		✓	✓	✓	✓
Offers a Subsidy for Low-income Individuals	✓	✓	✓		✓
Less Comprehensive Benefits Package	✓		✓		✓
Purchasing Pool or Connector	✓	✓	✓		✓
Insurance Market Reform		✓		✓	✓

**Table 1**  
**Comparing Selected Proposals for Comprehensive Health Care Reform**  
**in Colorado (Cont.)**

	Better Health Care for Colorado	A Plan for Covering Colorado	Solutions for Healthy Colorado	Colorado Health Services Program	208 Commission's Fifth Proposal
Consolidate Insurance Market		✓			
Expand Medicaid and CHP+	✓	✓	✓		✓
Reform Medicaid and CHP+	✓	✓		✓	✓
Single-Payer				✓	*

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.

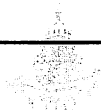
**Committee recommendation.** As a result of these discussions, the task force recommends Bill A. The bill extends the Prescription Drug Information and Technical Assistance Program that was established in 2006 within the Department of Health Care Policy and Financing to provide advice about prescription 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**

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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.





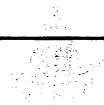
**Provider shortages.** Nursing and physician shortages in Colorado have increased in part because of issues such as increased utilization of health services; an increase in the diagnosis of chronic conditions, such as diabetes, asthma, and obesity; an increase in the aging population; and an increased 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**

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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](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

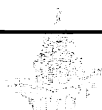
- ◆ Overview of the 208 Commission activities
- ◆ Presentation of the proposed health care plan from the Colorado Health Services Program
- ◆ Presentation of the proposed health care plan from the Solutions for a Healthy Colorado
- ◆ Presentation of the proposed health care plan from the A Plan for Covering 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



November 1, 2007

- ◆ Presentation of the fifth proposal for a new health care plan for the state
- ◆ Discussion and approval of proposed committee legislation



DRAFT

LLS NO. 08-0331.01 Kristen Forrestal

INTERIM COMMITTEE BILL

Health Care Task Force

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A BILL FOR AN ACT

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

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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.

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

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

5           **25.5-1-203. Prescription drug information and technical**  
6 **assistance program - expansion.** THE STATE DEPARTMENT MAY EXPAND  
7 THE PRESCRIPTION DRUG INFORMATION AND TECHNICAL ASSISTANCE  
8 PROGRAM CREATED IN SECTION 25.5-5-507, TO INCLUDE PERSONS  
9 RECEIVING DRUG BENEFITS PURSUANT TO ANY PROGRAM THAT IS  
10 ADMINISTERED BY THE STATE DEPARTMENT.

11           **SECTION 2. Safety clause.** The general assembly hereby finds,  
12 determines, and declares that this act is necessary for the immediate  
13 preservation of the public peace, health, and safety. <{ask committee}>

DRAFT

LLS NO. 08-0309.01 Jerry Barry

COMMITTEE BILL

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Health Care Task Force

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A BILL FOR AN ACT

101 CONCERNING ELIGIBILITY UNDER THE FAMILY PLANNING PILOT  
102 PROGRAM.

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**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.

---

1 *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.*



1           **SECTION 1.** 25.5-5-319 (1), Colorado Revised Statutes, is  
2 amended to read:

3           **25.5-5-319. Family planning pilot program - rules - federal**  
4 **waiver - repeal.** (1) There is hereby established a family planning pilot  
5 program for the provision of family planning services to categorically  
6 eligible individuals who are at or below ~~one hundred fifty percent~~ A  
7 PERCENTAGE of the federal poverty level ESTABLISHED PURSUANT TO THE  
8 FEDERAL WAIVER SOUGHT PURSUANT TO SUBSECTION (2) OF THIS SECTION.  
9 The state board shall promulgate rules setting forth the family planning  
10 services to be provided under the family planning pilot program.

11           **SECTION 2. Safety clause.** The general assembly hereby finds,  
12 determines, and declares that this act is necessary for the immediate  
13 preservation of the public peace, health, and safety. <{*Does the task*  
14 *force want a safety clause?*>

DRAFT

LLS NO. 08-0330.01 Jerry Barry

INTERIM COMMITTEE BILL

Health Care Task Force

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A BILL FOR AN ACT

101 CONCERNING A CHANGE IN THE DISPENSING FEE PAID TO PHARMACIES  
102 FOR CERTAIN DRUGS UNDER MEDICAID.

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**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

*Capital letters indicate new material to be added to existing statute.  
Dashes through the words indicate deletions from existing statute.*

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.

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

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

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

8           (a) THE FEDERAL "DEFICIT REDUCTION ACT OF 2005", PUB.L.  
9 109-107, CHANGED THE CALCULATION OF THE FEDERAL UPPER PAYMENT  
10 LIMIT FOR GENERIC AND NONPATENTED DRUGS TO TWO HUNDRED FIFTY  
11 PERCENT OF THE AVERAGE MANUFACTURER PRICE.

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

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

22           (d) WITHOUT OTHER CHANGES, IF THE CHANGE IN CALCULATING

1 THE FEDERAL UPPER PAYMENT LIMIT BECOMES EFFECTIVE, MANY LOCAL  
2 PHARMACIES IN COLORADO WILL BE UNABLE TO FILL PRESCRIPTIONS FOR  
3 MEDICAID RECIPIENTS AND MAY BE FORCED TO CLOSE.

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

8 (2) THE STATE DEPARTMENT SHALL REVIEW THE IMPACT OF THE  
9 CHANGE IN THE CALCULATION OF THE FEDERAL UPPER PAYMENT LIMIT FOR  
10 GENERIC AND NONPATENTED DRUGS REQUIRED BY THE "DEFICIT  
11 REDUCTION ACT OF 2005" TO DETERMINE THE AMOUNT OF THE  
12 REDUCTION FOR REIMBURSEMENT THAT PHARMACIES SHALL INCUR  
13 BECAUSE OF THE CHANGE AND THE AMOUNT THAT THE DISPENSING FEE  
14 FOR GENERIC AND NONPATENTED DRUGS WOULD NEED TO BE INCREASED  
15 TO OFFSET THIS REDUCTION. THE STATE DEPARTMENT SHALL SUBMIT TO  
16 THE FEDERAL GOVERNMENT AN AMENDMENT TO THE STATE PLAN FOR  
17 MEDICAL ASSISTANCE THAT SEEKS TO INCREASE THE DISPENSING FEE FOR  
18 GENERIC AND NONPATENTED DRUGS STARTING ON THE EFFECTIVE DATE OF  
19 ANY CHANGE IN THE REIMBURSEMENT RATE FOR THE REMAINDER OF THE  
20 STATE FISCAL YEAR BEGINNING JULY 1, 2007, TO OFFSET THE REDUCTION  
21 IN THE REIMBURSEMENT RATE FOR SUCH DRUGS. THE INCREASE IN THE  
22 DISPENSING FEE REQUIRED BY THIS SUBSECTION (2) SHALL TAKE EFFECT  
23 ONLY IF THE CHANGE IN THE CALCULATION OF THE FEDERAL UPPER  
24 PAYMENT LIMIT REQUIRED BY THE "DEFICIT REDUCTION ACT OF 2005"  
25 TAKES EFFECT.

26 (3) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2009.

1           **SECTION 2. Safety clause.** The general assembly hereby finds,  
2 determines, and declares that this act is necessary for the immediate  
3 preservation of the public peace, health, and safety. <*Does the*  
4 *committee want a safety clause? To be effective during the 2007 fiscal*  
5 *year, the bill will require a safety clause.*>

DRAFT

LLS NO. 08-0333.01 Christy Chase

INTERIM COMMITTEE BILL

Health Care Task Force

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A BILL FOR AN ACT

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

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

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

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

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

14           (b) (I) MEDICAL PAYMENTS COVERAGE OF AT LEAST FIFTEEN

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

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

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

26 (A) BENEFITS SHALL FIRST BE PAID TO FIRST RESPONDERS AND TO  
27 A HOSPITAL OR TRAUMA CENTER WHOSE EMERGENCY DEPARTMENT  
28 PHYSICIANS AND STAFF OR TRAUMA SERVICE CALL PANEL PHYSICIANS AND  
29 STAFF PROVIDE CARE IMMEDIATELY AFTER A MOTOR VEHICLE ACCIDENT.



1 (B) ANY REMAINING BENEFITS SHALL BE PAID TO PROVIDERS  
2 DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH (b) WHO PROVIDE  
3 SUBSEQUENT HEALTH CARE SERVICES.

4 (IV) EXCEPT AS PROVIDED IN SUBPARAGRAPH (V) OF THIS  
5 PARAGRAPH (b), MEDICALLY NECESSARY AND ACCIDENT-RELATED HEALTH  
6 CARE PROVIDED TO A PERSON CLAIMING MEDICAL PAYMENTS COVERAGE  
7 SHALL BE REIMBURSED AS FOLLOWS:

8 (A) FOR EXPENSES RELATED TO SERVICES PROVIDED BY PROVIDERS  
9 DESCRIBED IN SUB-SUBPARAGRAPH (A) OF SUBPARAGRAPH (III) OF THIS  
10 PARAGRAPH (b), TWO HUNDRED PERCENT OF THE 2006 MEDICARE  
11 RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS) FEE SCHEDULE,  
12 ADJUSTED BY THE GEOGRAPHICAL PRACTICE COST INDEX, OR A SUCCESSOR  
13 INDEX; AND

14 (B) FOR EXPENSES RELATED TO SERVICES PROVIDED BY PROVIDERS  
15 DESCRIBED IN SUB-SUBPARAGRAPH (B) OF SUBPARAGRAPH (III) OF THIS  
16 PARAGRAPH (b), ONE HUNDRED FIFTY PERCENT OF THE 2006 MEDICARE  
17 RBRVS FEE SCHEDULE, ADJUSTED BY THE GEOGRAPHICAL PRACTICE COST  
18 INDEX, OR A SUCCESSOR INDEX.

19 (V) NOTHING IN THIS PARAGRAPH (b) SHALL LIMIT THE ABILITY OF  
20 AN INJURED PERSON TO CHOOSE OR CHANGE HIS OR HER HEALTH CARE  
21 PROVIDER.

22 (VI) AN INSURER SHALL HONOR A PROPER ASSIGNMENT OF  
23 MEDICAL PAYMENTS COVERAGE BENEFITS MADE PURSUANT TO SECTION  
24 10-4-634 AND SHALL PROMPTLY PAY CLAIMS FOR MEDICAL PAYMENTS  
25 COVERAGE IN ACCORDANCE WITH SECTION 10-4-642.

26 (VII) AS USED IN THIS PARAGRAPH (b), UNLESS THE CONTEXT  
27 OTHERWISE REQUIRES:

28 (A) "FIRST RESPONDER" MEANS A PERSON OR ENTITY THAT  
29 RESPONDS TO, AND PROVIDES EMERGENCY MEDICAL CARE TO AN

1 INDIVIDUAL INJURED IN, A MOTOR VEHICLE ACCIDENT. THE TERM  
2 INCLUDES, BUT IS NOT LIMITED TO, A PERSON OR ENTITY PROVIDING  
3 AMBULANCE SERVICE, INCLUDING AIR AMBULANCE SERVICE, AN  
4 EMERGENCY MEDICAL TECHNICIAN, AS DEFINED IN SECTION 25-3.5-103  
5 (8), C.R.S., AND ANY SERVICE AGENCY, AS DEFINED IN SECTION 25-3.5-103  
6 (11.5), C.R.S., OR OTHER PERSON OR ENTITY THAT PROVIDES EMERGENCY  
7 MEDICAL CARE AT THE SCENE OF OR IMMEDIATELY AFTER A MOTOR  
8 VEHICLE ACCIDENT. "FIRST RESPONDER" DOES NOT INCLUDE A HOSPITAL.

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

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

28 **SECTION 2. Repeal.** 10-4-635 (1), Colorado Revised Statutes,  
29 is repealed as follows:

1           **10-4-635. Medical payments coverage - no tort recovery.**

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

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

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

13           (b) IF THE INSURED ALSO HAS HEALTH INSURANCE COVERAGE, THE  
14           medical payments coverage:

15           (I) Is primary to ~~any~~ THE health insurance coverage available to  
16           ~~an~~ THE insured when injured in ~~an automobile~~ A MOTOR VEHICLE  
17           accident;

18           (II) SHALL PROVIDE COVERAGE BEFORE THE HEALTH INSURANCE  
19           COVERAGE; AND

20           (III) SHALL APPLY TO ANY COINSURANCE OR DEDUCTIBLE AMOUNT  
21           REQUIRED BY THE HEALTH INSURANCE COVERAGE PLAN OR POLICY;

22           **SECTION 4. Effective date - applicability.** This act shall take  
23           effect January 1, 2009, and shall apply to automobile insurance policies  
24           issued, delivered, or renewed on or after said date.

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

DRAFT

LLS NO. 08-0332.01 Christy Chase

INTERIM COMMITTEE BILL

Health Care Task Force

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A BILL FOR AN ACT

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

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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.

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

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

4   PART 9

5           EMERGENCY RESPONDERS AND TRAUMA CARE  
6   REIMBURSEMENT PROGRAM

7           **25-3.5-901. Definitions.** AS USED IN THIS PART 9, UNLESS THE  
8 CONTEXT OTHERWISE REQUIRES:

9                   (1) "FUND" MEANS THE EMERGENCY RESPONDERS AND TRAUMA  
10 CARE REIMBURSEMENT FUND CREATED IN SECTION 25-3.5-903.

11                   (2) "LICENSED AIR AMBULANCE" MEANS AN AIR AMBULANCE, AS  
12 DEFINED IN SECTION 25-3.5-103 (1), THAT IS LICENSED BY THE  
13 DEPARTMENT PURSUANT TO SECTION 25-3.5-307.

14                   (3) "LICENSED AMBULANCE" MEANS AN AMBULANCE, AS DEFINED  
15 IN SECTION 25-3.5-103 (1.5), THAT IS LICENSED PURSUANT TO SECTION  
16 25-3.5-301.

17                   (4) "PROGRAM" MEANS THE EMERGENCY RESPONDERS AND  
18 TRAUMA CARE REIMBURSEMENT PROGRAM CREATED IN SECTION  
19 25-3.5-902 (1).

20                   (5) "PROGRAM ADMINISTRATOR" MEANS THE ENTITY SELECTED BY  
21 THE DIRECTOR PURSUANT TO SECTION 25-3.5-902 (2) TO ADMINISTER THE  
22 PROGRAM.

23                   (6) "PROVIDER" MEANS A LICENSED AMBULANCE, LICENSED AIR  
24 AMBULANCE, TRAUMA PHYSICIAN, OR TRAUMA CENTER THAT PROVIDES  
25 TRAUMA CARE TO A TRAUMA PATIENT INJURED IN A MOTOR VEHICLE  
26 ACCIDENT.

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

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

12           (9) "TRAUMA CARE" OR "EMERGENCY MEDICAL CARE" MEANS  
13 CARE PROVIDED BY A LICENSED AMBULANCE OR AIR AMBULANCE, TRAUMA  
14 PHYSICIAN, OR TRAUMA CENTER TO A TRAUMA PATIENT INJURED IN A  
15 MOTOR VEHICLE ACCIDENT FROM THE TIME THE ADMINISTRATION OF CARE  
16 BEGINS TO THE TIME THE PATIENT IS FULLY STABILIZED OR THROUGH THE  
17 FIRST EPISODE OF CARE, NOT TO EXCEED SEVENTY-TWO HOURS AFTER THE  
18 ADMINISTRATION OF CARE BEGINS. THE TERM INCLUDES A TRAUMA CARE  
19 SYSTEM, TRAUMA TRANSPORT PROTOCOLS, AND TRIAGE, AS DEFINED IN  
20 SECTION 25-3.5-703 (10), (11), AND (12), RESPECTIVELY.

21           (10) "TRAUMA CENTER" MEANS A HEALTH CARE FACILITY OR AN  
22 EMERGENCY DEPARTMENT IN A LICENSED OR CERTIFIED HOSPITAL THAT IS  
23 DESIGNATED BY THE DEPARTMENT AS A LEVEL I, II, III, IV, OR V FACILITY,  
24 OR A HEALTH CARE FACILITY DESIGNATED BY THE DEPARTMENT AS A  
25 REGIONAL PEDIATRIC TRAUMA CENTER.

26           (11) "TRAUMA PHYSICIAN" MEANS A TRAUMA SURGEON,  
27 ORTHOPEDIC SURGEON, NEUROSURGEON, INTENSIVE CARE UNIT PHYSICIAN,

1 ANESTHESIOLOGIST, OR PHYSICIAN WHO PROVIDES CARE IN A TRAUMA  
2 CENTER TO A TRAUMA PATIENT INJURED IN A MOTOR VEHICLE ACCIDENT.

3 (12) "UNCOMPENSATED TRAUMA CARE" MEANS TRAUMA CARE  
4 PROVIDED BY A LICENSED AMBULANCE OR AIR AMBULANCE, TRAUMA  
5 PHYSICIAN, OR TRAUMA CENTER TO A TRAUMA PATIENT WHO HAS NOT  
6 PAID FOR THE TRAUMA CARE AFTER DOCUMENTED ATTEMPTS BY THE  
7 PROVIDER TO COLLECT PAYMENT OWED BY THE PATIENT AND WHO:

8 (a) (I) HAS COPAYMENT OR DEDUCTIBLE HEALTH INSURANCE  
9 RESPONSIBILITY; OR

10 (II) DOES NOT HAVE HEALTH INSURANCE COVERAGE OR MEDICARE  
11 COVERAGE OR DOES NOT HAVE ANY OR A SUFFICIENT AMOUNT OF MEDICAL  
12 PAYMENTS COVERAGE UNDER AN AUTOMOBILE INSURANCE POLICY; AND

13 (b) IS NOT ELIGIBLE FOR COVERAGE UNDER THE "COLORADO  
14 MEDICAL ASSISTANCE ACT", ARTICLE 4 OF TITLE 25.5, C.R.S.

15 **25-3.5-902. Emergency responders and trauma care**  
16 **reimbursement program - creation - administration.** (1) THERE IS  
17 HEREBY ESTABLISHED, IN THE DEPARTMENT, THE EMERGENCY  
18 RESPONDERS AND TRAUMA CARE REIMBURSEMENT PROGRAM, ALSO  
19 REFERRED TO IN THIS SECTION AS THE "PROGRAM". THE PURPOSE OF THE  
20 PROGRAM SHALL BE TO PROVIDE REIMBURSEMENT OF UNCOMPENSATED  
21 TRAUMA CARE PROVIDED BY A LICENSED AMBULANCE OR AIR AMBULANCE,  
22 TRAUMA PHYSICIAN, OR TRAUMA CENTER TO A TRAUMA PATIENT INJURED  
23 IN A MOTOR VEHICLE ACCIDENT THAT OCCURS WITHIN THE STATE OF  
24 COLORADO.

25 (2) (a) BY JANUARY 1, 2009, THE DIRECTOR SHALL IDENTIFY AN  
26 ENTITY TO ADMINISTER THE PROGRAM, BASED ON INFORMATION  
27 INDICATING WHICH ENTITY HAS THE ABILITY TO ADMINISTER THE



1 PROGRAM IN THE MOST EFFECTIVE AND EFFICIENT MANNER. THE  
2 DIRECTOR SHALL TAKE INTO CONSIDERATION THE ABILITY OF THE ENTITY  
3 TO:

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

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

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

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

25 (d) THE PROGRAM ADMINISTRATOR SHALL MAKE EVERY EFFORT TO  
26 START THE PROGRAM AS SOON AS POSSIBLE AFTER THE DIRECTOR MAKES  
27 HIS OR HER SELECTION PURSUANT TO THIS SUBSECTION (2), BUT IN NO

1 EVENT SHALL THE PROGRAM BE STARTED LATER THAN JULY 1, 2009.

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

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

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

22 (II) THAT THE APPLICANT IS EITHER A LICENSED AMBULANCE OR  
23 AIR AMBULANCE, TRAUMA PHYSICIAN, OR TRAUMA CENTER THAT HAS  
24 PROVIDED UNCOMPENSATED TRAUMA CARE ON OR AFTER JANUARY 1,  
25 2009, TO A TRAUMA PATIENT INJURED IN A MOTOR VEHICLE ACCIDENT  
26 THAT OCCURRED WITHIN THE STATE OF COLORADO;

27 (III) THAT THE APPLICANT HAS PROVIDED DOCUMENTATION OF THE

1 TRAUMA CARE PROVIDED TO THE TRAUMA PATIENT, INCLUDING THE DATE  
2 THE TRAUMA CARE WAS PROVIDED, THE NATURE AND EXTENT OF THE  
3 TRAUMA CARE, THE MEDICAL NECESSITY FOR THE TRAUMA CARE, AND THE  
4 REQUESTED REIMBURSEMENT FOR THE TRAUMA CARE; AND

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

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

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

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

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

1 PRIORITY.

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

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

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

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

26 (e) THE PROGRAM ADMINISTRATOR SHALL MAKE REIMBURSEMENT  
27 PAYMENTS FROM THE FUND TO QUALIFIED APPLICANTS AT LEAST

1 ANNUALLY OR MORE FREQUENTLY AS DETERMINED APPROPRIATE BY THE  
2 PROGRAM ADMINISTRATOR. THE PROGRAM ADMINISTRATOR SHALL  
3 ESTABLISH DEADLINES WITHIN WHICH APPLICANTS SHALL FILE  
4 REIMBURSEMENT APPLICATIONS.

5 **25-3.5-903. Emergency responders and trauma care**  
6 **reimbursement fund - creation - use.** (1) THERE IS HEREBY  
7 ESTABLISHED IN THE STATE TREASURY THE EMERGENCY RESPONDERS AND  
8 TRAUMA CARE REIMBURSEMENT FUND. THE FUND SHALL CONSIST OF ALL  
9 MONEYS CREDITED THERETO IN ACCORDANCE WITH SECTION 42-3-304  
10 (25), C.R.S., AND ANY MONEYS RECOVERED BY THE ADMINISTRATOR FROM  
11 TRAUMA PATIENTS OR OTHER PARTIES RESPONSIBLE FOR THE PAYMENT OF  
12 TRAUMA CARE THAT WAS REIMBURSED BY THE FUND. ALL INTEREST  
13 EARNED ON THE INVESTMENT OF MONEYS IN THE FUND SHALL BE CREDITED  
14 TO THE FUND. THE MONEYS IN THE FUND ARE HEREBY CONTINUOUSLY  
15 APPROPRIATED FOR THE PURPOSES SET FORTH IN THIS SECTION. ANY  
16 MONEYS CREDITED TO THE FUND AND UNEXPENDED AT THE END OF ANY  
17 GIVEN FISCAL YEAR SHALL REMAIN IN THE FUND AND SHALL NOT REVERT  
18 TO THE GENERAL FUND OR ANY OTHER FUND.

19 (2) OF THE MONEYS IN THE FUND, NOT MORE THAN THREE PERCENT  
20 SHALL BE USED FOR PROGRAM ADMINISTRATIVE COSTS, INCLUDING THE  
21 ADMINISTRATIVE COSTS OF THE DIVISION AND OF THE ENTITY SELECTED AS  
22 THE PROGRAM ADMINISTRATOR.

23 (3) THE MONEYS REMAINING IN THE FUND AFTER THE PAYMENT OF  
24 ADMINISTRATIVE COSTS SHALL BE USED TO PROVIDE REIMBURSEMENT TO  
25 LICENSED AMBULANCE AND AIR AMBULANCES, TRAUMA PHYSICIANS, AND  
26 TRAUMA CENTERS FOR UNCOMPENSATED TRAUMA CARE AS SPECIFIED IN  
27 SECTION 25-3.5-902.

1           **25-3.5-904. Annual report.** (1) BY JANUARY 1, 2012, AND EACH  
2 JANUARY 1 THEREAFTER, THE PROGRAM ADMINISTRATOR SHALL SUBMIT  
3 AN ANNUAL REPORT TO THE HEALTH AND HUMAN SERVICES COMMITTEES  
4 OF THE SENATE AND THE HOUSE OF REPRESENTATIVES, OR ANY SUCCESSOR  
5 COMMITTEES, REGARDING THE PROGRAM. THE REPORT SHALL INCLUDE  
6 DETAILED INFORMATION REGARDING:

7           (a) THE TOTAL NUMBER OF REIMBURSEMENT APPLICATIONS  
8 RECEIVED SINCE THE START OF THE PROGRAM AND THE NUMBER OF  
9 APPLICATIONS RECEIVED EACH YEAR;

10           (b) THE NUMBER AND TYPES OF PROVIDERS WHO APPLY FOR  
11 REIMBURSEMENT;

12           (c) THE TOTAL AMOUNT OF REIMBURSEMENT PAYMENTS MADE  
13 SINCE THE START OF THE PROGRAM, SPECIFYING THE AMOUNTS PAID EACH  
14 YEAR;

15           (d) THE RECIPIENTS OF REIMBURSEMENT PAYMENTS, INCLUDING  
16 THE TYPE OF PROVIDER, THE NUMBER OF REIMBURSEMENT APPLICATIONS  
17 MADE BY EACH RECIPIENT, THE AMOUNT OF EACH REIMBURSEMENT MADE  
18 TO EACH RECIPIENT, AND THE TOTAL AMOUNT REQUESTED BY AND PAID TO  
19 EACH RECIPIENT;

20           (e) FOR EACH YEAR SINCE THE PROGRAM STARTED, THE TOTAL  
21 AMOUNT OF MONEYS CREDITED TO AND EXPENDED FROM THE FUND, THE  
22 TOTAL DOLLAR AMOUNTS OF ALL PAYMENT REQUESTS, THE TOTAL DOLLAR  
23 AMOUNTS EXPENDED FROM THE FUND FOR REIMBURSEMENT PAYMENTS,  
24 AND THE ADMINISTRATIVE EXPENSES OF THE PROGRAM;

25           (f) ANY BALANCE REMAINING IN THE FUND AT THE END OF THE  
26 FISCAL YEAR, THE AMOUNT REIMBURSED TO THE FUND THROUGH  
27 SUBROGATION, AN EXPLANATION OF THE OUTSTANDING FUND BALANCE,

1 REVENUES PROJECTED TO BE DEPOSITED INTO THE FUND IN THE NEXT FIVE  
2 FISCAL YEARS, AND THE ESTIMATED REIMBURSEMENT NEEDS FOR THE  
3 NEXT FIVE FISCAL YEARS;

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

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

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

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

17 **10-4-620. Required coverage - definitions.** (1) Subject to the  
18 limitations and exclusions authorized by this part 6, the basic coverage  
19 required for compliance with this part 6 is:

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

26 (b) (I) EMERGENCY MEDICAL CARE COVERAGE FOR BODILY INJURY  
27 ARISING OUT OF THE USE OF THE MOTOR VEHICLE WITH BENEFITS OF AT

1 LEAST FIFTEEN THOUSAND DOLLARS FOR ALL REASONABLE, NECESSARY,  
2 AND ACCIDENT-RELATED EMERGENCY MEDICAL CARE PROVIDED TO AN  
3 INJURED PERSON BY A LICENSED AMBULANCE OR AIR AMBULANCE,  
4 TRAUMA PHYSICIAN, OR TRAUMA CENTER AT THE SCENE OF OR  
5 IMMEDIATELY AFTER A MOTOR VEHICLE ACCIDENT. IF THE INJURED  
6 PERSON FOR WHOM EMERGENCY MEDICAL CARE COVERAGE IS PAID IS  
7 FOUND NOT AT FAULT IN THE ACCIDENT, THE INSURER THAT PAID THE  
8 COVERAGE SHALL BE SUBROGATED TO THE RIGHTS OF THE INJURED PERSON  
9 AGAINST THE AT-FAULT PERSON, TO THE EXTENT OF THE PAYMENTS MADE,  
10 AFTER THE INJURED PERSON IS FULLY COMPENSATED FOR INJURIES  
11 SUSTAINED IN THE ACCIDENT.

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

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

19 (A) "EMERGENCY MEDICAL CARE" OR "TRAUMA CARE" MEANS  
20 CARE PROVIDED BY A LICENSED AMBULANCE OR AIR AMBULANCE, TRAUMA  
21 PHYSICIAN, OR TRAUMA CENTER TO A TRAUMA PATIENT INJURED IN A  
22 MOTOR VEHICLE ACCIDENT FROM THE TIME THE ADMINISTRATION OF CARE  
23 BEGINS TO THE TIME THE PATIENT IS FULLY STABILIZED OR THROUGH THE  
24 FIRST EPISODE OF CARE, NOT TO EXCEED SEVENTY-TWO HOURS AFTER THE  
25 ADMINISTRATION OF CARE BEGINS. THE TERM INCLUDES A TRAUMA CARE  
26 SYSTEM, TRAUMA TRANSPORT PROTOCOLS, AND TRIAGE, AS DEFINED IN  
27 SECTION 25-3.5-703 (10), (11), AND (12), RESPECTIVELY.



1 (B) "INJURED PERSON" MEANS THE INSURED, OR A PASSENGER WHO  
2 IS AUTHORIZED BY THE INSURED TO OCCUPY THE INSURED'S MOTOR  
3 VEHICLE, WHO SUSTAINS BODILY INJURY ARISING OUT OF THE USE OF THE  
4 INSURED'S MOTOR VEHICLE.

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

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

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

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

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

1 AS A REGIONAL PEDIATRIC TRAUMA CENTER.

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

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

8 **42-3-304. Registration fees - passenger and passenger-mile**  
9 **taxes - clean screen fund - repeal.** (25) (a) IN ORDER TO PROVIDE  
10 FUNDING FOR EMERGENCY MEDICAL CARE NECESSITATED BY THE  
11 OCCURRENCE OF MOTOR VEHICLE ACCIDENTS ON HIGHWAYS THROUGHOUT  
12 THE STATE, IN ADDITION TO ANY OTHER FEES IMPOSED BY THIS SECTION,  
13 ON AND AFTER JULY 1, 2008, THERE SHALL BE ASSESSED AN ADDITIONAL  
14 FEE OF SIXTEEN DOLLARS AT THE TIME OF REGISTRATION OF ANY MOTOR  
15 VEHICLE EXCEPT A FLEET VEHICLE. THE FEE SHALL BE TRANSMITTED TO  
16 THE STATE TREASURER, WHO SHALL CREDIT THE SAME TO THE EMERGENCY  
17 RESPONDERS AND TRAUMA CARE REIMBURSEMENT FUND CREATED IN  
18 SECTION 25-3.5-903, C.R.S.

19 (b) NOTWITHSTANDING THE AMOUNT SPECIFIED FOR THE FEE IN  
20 PARAGRAPH (a) OF THIS SUBSECTION (25), THE DIRECTOR BY RULE OR AS  
21 OTHERWISE PROVIDED BY LAW MAY REDUCE THE AMOUNT OF THE FEE IF  
22 NECESSARY PURSUANT TO SECTION 24-75-402 (3), C.R.S., TO REDUCE THE  
23 UNCOMMITTED RESERVES OF THE EMERGENCY RESPONDERS AND TRAUMA  
24 CARE REIMBURSEMENT FUND CREATED IN SECTION 25-3.5-903, C.R.S.  
25 AFTER THE UNCOMMITTED RESERVES OF THE FUND ARE SUFFICIENTLY  
26 REDUCED, THE DIRECTOR BY RULE OR AS OTHERWISE PROVIDED BY LAW  
27 MAY INCREASE THE AMOUNT OF THE FEE AS PROVIDED IN SECTION

1 24-75-402 (4), C.R.S.

2           **SECTION 4. Effective date - applicability.** (1) Except as  
3 provided in subsection (2) of this section, this act shall take effect upon  
4 passage.

5           (2) Section 2 of this act shall take effect January 1, 2009, and shall  
6 apply to automobile insurance policies issued, delivered, or renewed on  
7 or after said date.

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