RECOMMENDATIONS FOR 2002

TASK FORCE TO EVALUATE HEALTH CARE NEEDS

Report to the
Colorado General Assembly

Research Publication No. 494
December 2001

COLORADO GENERAL ASSEMBLY

LEGISLATIVE COUNCIL

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December 2001

To Members of the Sixty-third General Assembly:

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

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

Respectfully submitted,

/s/ Senator Stan Matsunaka
Chairman
Legislative Council

SM/JG/kd

TABLE OF CONTENTS

PAGE

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

RECOMMENDED BILLS AND FISCAL NOTES

PAGE

TASK FORCE TO EVALUATE HEALTH CARE NEEDS FOR COLORADO

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EXECUTIVE SUMMARY

Committee Charge

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

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

Committee Activities

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

committee also considered testimony from insurance carriers, a wide range of health care providers, small employers, pharmacists, state employees, PERA, the Department of Regulatory Agencies - Division of Insurance, and the Department of Personnel/General Support Services at these meetings.

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

Committee Recommendations

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

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

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

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

Bill D — Guaranteed Issue of Health Insurance Benefits for Business Groups of One. The bill eliminates the requirement that a business group of one work 24 hours per week in order to qualify as such. The bill clarifies that carriers offering health benefit coverage

to small employers may reduce benefits by 50 percent for business groups of one for up to 12 months.

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

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

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

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

due to delinquent premiums. The bill establishes time frames for claims to be paid, denied, or settled, and establishes penalties for noncompliance.

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

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

STATUTORY AUTHORITY AND RESPONSIBILITIES

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

COMMITTEE ACTIVITIES

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

Primary Concerns

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

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

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

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

Medical Professional Shortage

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

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

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

Health Care Provider Issues

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

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

Rural Hospitals

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

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

State Employee Issues

The Department of Personnel/General Support Services informed the committee that the state is experiencing premium increases ranging between 25 to 40 percent for 2002. Even greater increases will occur for carriers who provide service to Pueblo County state employees. Insurance coverage options for

state employees in other rural communities is often limited to one provider, and coverage is expensive. As a result, the state is having a difficult time recruiting and retaining rural area employees. Wages in these areas trend to be low, and the benefits offered by the state are no longer as attractive as those offered by other employers.

Children's Health Issues

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

Small Group Market/Business Group of One

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

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

SUMMARY OF RECOMMENDATIONS

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

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

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

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

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

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

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

beginning on and after January 1, 2003, the bill expands the tax credit by making registered nurses, licensed practical nurses, medical technicians and pharmacists eligible for the tax credit.

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

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

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

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

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

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

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

Bill G — Concerning the Definition of Basic Health Benefit Coverage

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

Bill H — Concerning Prompt Payment of Health Insurance Claims

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

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

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

Bill J — Concerning Expanded Access to Health Insurance

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

RESOURCE MATERIALS

The resource materials listed below were provided to the committee or developed by Legislative Council staff during the course of the meetings. The summaries of meetings and attachments are available at the Division of Archives, 1313 Sherman Street, Denver, (303) 866-2055. For a limited time, the meeting summaries and materials developed by Legislative Council Staff are available on our web site at: www. state.co.us/gov_dir/leg_dir/lcsstaff/2001/01interim.

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

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

Memoranda and Reports

Reports provided to the committee:

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

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

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

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

Second Regular Session
Sixty-third General Assembly
STATE OF COLORADO

DRAFT

LLS NO. 02-0112.02 Julie Hoerner **SENATE BILL**

SENATE SPONSORSHIP

Hagedorn

HOUSE SPONSORSHIP

Spradley

A BILL FOR AN ACT

101 **CONCERNING THE DEFINITION OF BASIC HEALTH BENEFIT COVERAGE.**

Bill Summary

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

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

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

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

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

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

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

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

10-16-104. Mandatory coverage provisions. (1) **Newborn children.** (a) All group and individual sickness and accident insurance policies ISSUED BY AN ENTITY SUBJECT TO PART 2 OF THIS ARTICLE and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article, NOT INCLUDING BASIC HEALTH BENEFIT PLANS, shall provide coverage for a

dependent newborn child of the insured or subscriber from the moment of birth.

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

(4) **Low-dose mammography.** (a) For the purposes of this subsection (4), "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and film and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. All individual and all group sickness and accident insurance policies, except BASIC HEALTH BENEFIT PLANS AND supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage provided to residents of this state, shall provide coverage for routine and certain diagnostic screening by low-dose mammography for the presence of breast cancer in adult women. Routine and diagnostic screenings provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar year basis by entities subject to part 2 or 3 of this article and shall not be subject to policy deductibles. Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. The minimum benefit required under this subsection (4) shall be adjusted to reflect

increases and decreases in the consumer price index. Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, which shall be specified in the policy or contract. The routine and diagnostic coverages provided pursuant to this subsection (4) shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. If an insured person who is eligible for a routine mammography screening benefit pursuant to subparagraphs (I), (II), and (III) of this paragraph (a), has not utilized such benefit during a calendar year or a contract year, then such provisions shall apply to one diagnostic screening for such year. If more than one diagnostic screening is provided for such person in a given calendar year or contract year, the other diagnostic service benefit provisions in the policy or contract shall apply with respect to such additional screenings. This mandated mammography coverage shall be provided according to the following guidelines:

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

(5.5) **Biologically based mental illness.** (a) (I) Every group policy, plan certificate, and contract of a carrier subject to the provisions of part 2, 3, or 4 of this article, except BASIC HEALTH BENEFIT PLANS AND those described in section 10-16-102 (21) (b), shall provide coverage for the treatment of biologically based mental illness that is no less extensive than the coverage provided for any other physical illness. Any preauthorization or utilization review mechanism used in the determination to provide such coverage shall be the same as, or no more restrictive than, that used in the determination to provide coverage for any other physical illness. The commissioner shall adopt such rules as are necessary to carry out the provisions of this subsection (5.5). In promulgating such rules, the commissioner shall recognize

that the substance of the mechanisms for preauthorization or utilization review may differ between medical specialities and that such mechanisms shall not be more restrictive with respect to a covered person or a mental health provider for a determination under this subparagraph (I) than for any other physical illness.

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

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

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

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

(12) **Hospitalization and general anesthesia for dental**

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

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

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

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

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

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

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

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

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

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

DRAFT

Colorado Legislative Council Staff

NO FISCAL IMPACT

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

TITLE: CONCERNING ALTERNATIVE HEALTH BENEFIT COVERAGE FOR SMALL EMPLOYERS.

Summary of Assessment

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

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

Departments Contacted

Regulatory Agencies