CHAPTER 300

INSURANCE

SENATE BILL 01-224

BY SENATOR(S) Hagedorn, Dyer (Durango), Fitz-Gerald, Hanna, Matsunaka, Nichol, Pascoe, Perlmutter, Takis, Thiebaut, Tupa, and Windels;
also REPRESENTATIVE(S) Spradley, Alexander, Boyd, Coleman, Fairbank, Hodge, Hoppe, Jahn, Kester, Mace, Miller, Plant, Rippy, Romanoff, Tapia, Tochtrop, Weddig, and Williams S.

AN ACT

CONCERNING THE ENHANCEMENT OF HEALTH CARE SERVICES FOR RURAL AREAS OF COLORADO, AND, IN CONNECTION THEREWITH, ENHANCING FLEXIBILITY FOR NETWORK ADEQUACY, CREATING COMMUNITY CONTRACTED HEALTH CARE PROVIDERS, EXPANDING THE USE OF TELEMEDICINE, AND CREATING AN INTERIM COMMITTEE TO STUDY HEALTH CARE ISSUES.

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

SECTION 1. Legislative declaration. (1) (a) The general assembly hereby finds that Coloradans are faced with increasing premiums for health insurance. Many employers, particularly small employers, have experienced significant increases in premium rates in the past year, thus making health insurance coverage increasingly unaffordable for the employer and the employee. Coloradans in rural areas of the state face problems associated with insufficient numbers of health care providers and difficulties obtaining health insurance coverage. Health insurance carriers and health care providers have faced increased difficulty entering into and maintaining mutually agreeable contracts for the coverage of health care services. Such contracts directly influence both access to, and affordability of, health care services.

(b) The general assembly also finds that telemedicine offers a unique opportunity to meet some of the needs of Coloradans in rural areas to obtain health care services in an efficient, yet cost-effective manner. Rural areas of the state are faced with limited access to appropriate health care providers to meet the requirements of a strong provider network. Telemedicine may offer a multifaceted approach to addressing the problem of provider distribution and the development of health systems in rural areas by improving communication capabilities and allowing for more convenient access to health care.

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

(c) Additionally, the general assembly finds that rural communities in Colorado may find relief for some health care needs through the ability of a town, municipality, or special district to contract directly with a health care provider to allow access to primary care.

(2) Therefore, the general assembly determines and declares that:

(a) The requirements of network adequacy need to be changed to allow additional flexibility within preferred provider organizations to allow greater access to health care;

(b) The abilities of a community to directly contract with health care providers for services may also address some issues facing rural Colorado;

(c) The general assembly should implement telemedicine to alleviate burdens faced by rural Coloradans to obtain necessary, reasonably priced and located health care services; and

(d) A task force should be created to evaluate other issues to improve access and affordability of health care services and health insurance coverage for such services during the interim after the first regular session of the sixty-third general assembly.

(3) The provisions of this act shall be known and cited as "The Colorado Rural Health Care Act of 2001".

SECTION 2. 10-16-102 (22), Colorado Revised Statutes, is amended, and the said 10-16-102 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

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

(22) "Health care services" means any services included in the furnishing to any individual of medical, mental, dental, or optometric care or hospitalization or nursing home care or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human physical or mental illness or injury. "HEALTH CARE SERVICES" INCLUDES THE RENDERING OF SUCH SERVICES THROUGH THE USE OF TELEMEDICINE.

(26.3) "LICENSED HEALTH CARE PROVIDER" SHALL HAVE THE SAME MEANING AS IN SECTION 10-4-902 (3).

SECTION 3. Part 1 of article 16 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-123. Telemedicine. (1) IT IS THE INTENT OF THE GENERAL ASSEMBLY TO RECOGNIZE THE PRACTICE OF TELEMEDICINE AS A LEGITIMATE MEANS BY WHICH AN INDIVIDUAL IN A RURAL AREA MAY RECEIVE MEDICAL SERVICES FROM A PROVIDER WITHOUT PERSON-TO-PERSON CONTACT WITH THE PROVIDER.

(2) ON OR AFTER JANUARY 1, 2002, NO HEALTH BENEFIT PLAN THAT IS ISSUED, AMENDED, OR RENEWED FOR A PERSON RESIDING IN A COUNTY WITH ONE HUNDRED FIFTY THOUSAND OR FEWER RESIDENTS MAY REQUIRE FACE-TO-FACE CONTACT BETWEEN A PROVIDER AND A COVERED PERSON FOR SERVICES APPROPRIATELY PROVIDED THROUGH TELEMEDICINE, PURSUANT TO SECTION 12-36-106 (1) (g), C.R.S., SUBJECT TO ALL TERMS AND CONDITIONS OF THE HEALTH BENEFIT PLAN, IF SUCH COUNTY HAS THE TECHNOLOGY NECESSARY FOR THE PROVISIONS OF TELEMEDICINE. ANY HEALTH BENEFITS PROVIDED THROUGH TELEMEDICINE SHALL MEET THE SAME STANDARD OF CARE AS FOR IN-PERSON CARE. NOTHING IN THIS SECTION SHALL REQUIRE THE USE OF TELEMEDICINE WHEN IN-PERSON CARE BY A PARTICIPATING PROVIDER IS AVAILABLE TO A COVERED PERSON WITHIN THE CARRIER'S NETWORK AND WITHIN THE MEMBER'S GEOGRAPHIC AREA.

(3) A HEALTH BENEFIT PLAN SHALL NOT BE REQUIRED TO PAY FOR CONSULTATION PROVIDED BY A PROVIDER BY TELEPHONE OR FACSIMILE.

SECTION 4. 10-16-704 (1) and (2), Colorado Revised Statutes, are amended, and the said 10-16-704 is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBSECTIONS, to read:

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

(a) Provider-covered person ratios by specialty, WHICH MAY INCLUDE THE USE OF PROVIDERS THROUGH TELEMEDICINE FOR SERVICES THAT MAY APPROPRIATELY BE PROVIDED THROUGH TELEMEDICINE;

(b) Primary care provider-covered person ratios;

(c) Geographic accessibility, WHICH IN SOME CIRCUMSTANCES MAY REQUIRE THE CROSSING OF COUNTY LINES;

(d) Waiting times for appointments with participating providers;

(e) Hours of operation; ~~and~~

(f) The volume of technological and specialty services available to serve the needs of covered persons requiring covered technologically advanced or specialty care; AND

(g) AN ADEQUATE NUMBER OF ACCESSIBLE ACUTE CARE HOSPITAL SERVICES WITHIN A REASONABLE DISTANCE, TRAVEL TIME, OR BOTH.

(2) (a) In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at

no greater cost to the covered person than if the benefit were obtained from participating providers.

(b) (I) A CARRIER OFFERING A MANAGED CARE PLAN WITH OUT-OF-NETWORK BENEFITS, THAT IS NOT A HEALTH MAINTENANCE ORGANIZATION OR A HEALTH MAINTENANCE ORGANIZATION WITH A POINT OF SERVICE PLAN, MAY REQUIRE THAT A COVERED PERSON TRAVEL A REASONABLE DISTANCE BEYOND THE REQUIREMENTS OF SUBSECTION (6) OF THIS SECTION FOR CARE WITHIN AN ADEQUATE PROVIDER NETWORK IN ORDER TO RECEIVE SERVICES FROM A PARTICIPATING PROVIDER. THIS PARAGRAPH (b) SHALL ONLY APPLY IF:

(A) THE COVERED PERSON RESIDES OUTSIDE OF A METROPOLITAN STATISTICAL AREA OR PRIMARY METROPOLITAN STATISTICAL AREA AND THE CARRIER HAS NO PARTICIPATING PROVIDERS TO PROVIDE COVERED BENEFITS IN SUCH GEOGRAPHIC AREA; AND

(B) THE CARRIER DEMONSTRATES UPON REQUEST BY THE COMMISSIONER, THAT THE CARRIER HAS MADE UNSUCCESSFUL GOOD FAITH EFFORTS TO CONTRACT WITH LOCAL PROVIDERS ON REASONABLE TERMS.

(II) SUBPARAGRAPH (I) OF THIS PARAGRAPH (b) SHALL NOT APPLY TO:

(A) EMERGENCY SERVICES OR PRIMARY CARE PROVIDERS; AND

(B) CASES IN WHICH THE COVERED PERSON IS SO SEVERELY ILL OR IMPAIRED THAT SUCH PERSON IS UNABLE TO MOVE FROM PLACE TO PLACE WITHOUT THE AIDE OF A MECHANICAL DEVICE; HAS A PHYSICAL OR MENTAL CONDITION, VERIFIED BY A PHYSICIAN LICENSED TO PRACTICE MEDICINE IN THIS STATE OR PRACTICING MEDICINE PURSUANT TO SECTION 12-36-106 (3) (i), C.R.S., THAT SUBSTANTIALLY LIMITS THE PERSON'S ABILITY TO MOVE FROM PLACE TO PLACE; OR SUFFERS FROM A PHYSICAL HARDSHIP SUCH THAT TRAVEL WOULD THREATEN THE SAFETY OR WELFARE OF THE COVERED PERSON AS VERIFIED BY THE COVERED PERSON'S IN-NETWORK TREATING PHYSICIAN. DECISIONS IN WHICH A CARRIER CONTESTS THE COVERED PERSON'S ABILITY TO TRAVEL MAY BE APPEALED PURSUANT TO SECTION 10-16-113 OR 10-16-113.5.

(c) (I) IN CASES WHERE, AS A RESULT OF THE PROVISIONS OF SUBPARAGRAPH (I) OF PARAGRAPH (b) OF THIS SUBSECTION (2), A COVERED PERSON IS REQUIRED TO TRAVEL A REASONABLE DISTANCE BEYOND THE REQUIREMENTS OF SUBSECTION (6) OF THIS SECTION FOR AN ADEQUATE NETWORK IN ORDER TO RECEIVE SERVICES FROM A PARTICIPATING PROVIDER, AND THE COVERED PERSON KNOWINGLY SEEKS SERVICES FROM A NONPARTICIPATING PROVIDER, THE CARRIER SHALL BE RESPONSIBLE TO PAY TO THE PROVIDER THE LESSER OF:

(A) THE NONPARTICIPATING PROVIDER'S BILL CHARGES;

(B) A NEGOTIATED RATE; OR

(C) IN THE ABSENCE OF A NEGOTIATED RATE, THE GREATER OF THE CARRIER'S AVERAGE IN-NETWORK RATE FOR THE RELEVANT GEOGRAPHIC AREA OR THE USUAL, CUSTOMARY, AND REASONABLE RATE FOR SUCH GEOGRAPHIC AREA. NOTHING IN THIS

PARAGRAPH (c) SHALL REQUIRE EITHER A CARRIER OR A NONPARTICIPATING PROVIDER TO ATTEMPT TO NEGOTIATE A REIMBURSEMENT RATE.

(II) UPON REQUEST THE CARRIER SHALL DISCLOSE TO THE COVERED PERSON OR THE NONPARTICIPATING PROVIDER WHETHER THE AMOUNT REIMBURSED TO THE NONPARTICIPATING PROVIDER WAS THE NONPARTICIPATING PROVIDER'S BILLED CHARGES, A NEGOTIATED RATE, OR THE GREATER OF THE CARRIER'S AVERAGE IN-NETWORK RATE FOR THE RELEVANT GEOGRAPHIC AREA OR THE USUAL, CUSTOMARY, AND REASONABLE RATE FOR SUCH GEOGRAPHIC AREA.

(III) A NONPARTICIPATING PROVIDER MAY BALANCE BILL THE COVERED PERSON IN THE EVENT THAT THE REIMBURSEMENT RATE DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH (c) IS NOT EQUAL TO THE BILLED CHARGES.

(IV) THE COMMISSIONER SHALL PROMULGATE RULES DEFINING THE RELEVANT GEOGRAPHIC AREA FOR THE PURPOSES OF SUB-SUBPARAGRAPH (C) OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (c). IN THE PROMULGATION OF SUCH RULES, THE COMMISSIONER SHALL GROUP TOGETHER COUNTIES WITH SIMILAR DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS. SUCH CHARACTERISTICS SHALL INCLUDE, BUT NOT BE LIMITED TO, AVERAGE PER CAPITA INCOME, THE COST OF HOUSING, GENERAL COST OF LIVING, POVERTY AND UNEMPLOYMENT LEVELS, OR THE PRIMARY ECONOMIC BASE OF THE COUNTY.

(d) THE CARRIER SHALL PROVIDE, IN CONSPICUOUS, BOLD-FACED TYPE, AN UNDERSTANDABLE DISCLOSURE IN POLICY CONTRACT MATERIALS, CERTIFICATES OF COVERAGE FOR A POLICYHOLDER, AND MARKETING MATERIALS ABOUT THE FOLLOWING:

(I) SPECIFIC COUNTIES OF THE STATE WHERE THERE ARE NO PARTICIPATING PROVIDERS;

(II) THE CIRCUMSTANCES UNDER WHICH THE COVERED PERSON MAY BE BALANCED BILLED BY NONPARTICIPATING PROVIDERS; AND

(III) THE MECHANISMS TO OBTAIN THE CARRIER'S REIMBURSEMENT RATES TO NONPARTICIPATING PROVIDERS FOR SPECIFIC COVERED HEALTH CARE SERVICES.

(e) (I) A CARRIER SHALL MAKE AVAILABLE UPON REQUEST FROM THE COVERED PERSON OR THE NONPARTICIPATING PROVIDER, FROM WHOM THE COVERED PERSON IS SEEKING TREATMENT, THE CARRIER'S USUAL, CUSTOMARY, AND REASONABLE RATE FOR REIMBURSEMENT FOR SPECIFIC HEALTH CARE SERVICES.

(II) THE COMMISSIONER MAY, UPON RECEIPT OF ONE OR MORE COMPLAINTS FROM A COVERED PERSON OR A COVERED PERSON'S NONPARTICIPATING TREATING PROVIDER, REVIEW THE CARRIER'S USUAL, CUSTOMARY, AND REASONABLE RATE TO DETERMINE IF THE RATE IS ESTABLISHED PURSUANT TO AN APPROPRIATE METHODOLOGY THAT IS BASED ON GENERALLY ACCEPTED INDUSTRY STANDARDS AND PRACTICES.

(III) THE CARRIER'S METHODOLOGY FOR DETERMINING USUAL, CUSTOMARY, AND

REASONABLE REIMBURSEMENT RATES SHALL BE APPLIED IN A UNIFORM MANNER STATEWIDE; EXCEPT THAT GEOGRAPHIC ADJUSTMENTS MAY BE MADE APART FROM THE STANDARD METHODOLOGY.

(f) FOR THE PURPOSES OF THIS SUBSECTION (2):

(I) "BALANCE BILL" MEANS THE AMOUNT THAT A NONPARTICIPATING PROVIDER MAY CHARGE THE COVERED PERSON. SUCH AMOUNT CHARGED EQUALS THE DIFFERENCE BETWEEN THE AMOUNT PAID BY THE CARRIER AND THE AMOUNT OF THE NONPARTICIPATING PROVIDER'S BILL CHARGE.

(II) "NEGOTIATED RATE" MEANS THE RATE MUTUALLY AGREED UPON BETWEEN THE CARRIER AND THE PROVIDER IN A SPECIFIC INSTANCE.

(III) "USUAL, CUSTOMARY, AND REASONABLE RATE" MEANS A RATE ESTABLISHED PURSUANT TO AN APPROPRIATE METHODOLOGY THAT IS BASED ON GENERALLY ACCEPTED INDUSTRY STANDARDS AND PRACTICES.

(2.5) (a) IN THE EVENT OF A MATERIAL CHANGE TO THE CARRIER'S NETWORK THAT COULD RESULT IN THE APPLICATION OF SUBPARAGRAPH (I) OF PARAGRAPH (b) OF SUBSECTION (2) OF THIS SECTION, THE CARRIER SHALL PROVIDE AT LEAST FORTY-FIVE DAYS PRIOR TO THE CHANGE, IN CONSPICUOUS BOLD-FACED TYPE, AN UNDERSTANDABLE DISCLOSURE TO ALL AFFECTED COVERED PERSONS ABOUT THE FOLLOWING:

(I) SPECIFIC NETWORK CHANGES IN THE GEOGRAPHIC AREA;

(II) THE CIRCUMSTANCES UNDER WHICH THE COVERED PERSON MAY BE BALANCED BILLED BY NONPARTICIPATING PROVIDERS; AND

(III) THE MECHANISMS TO OBTAIN THE CARRIER'S REIMBURSEMENT RATES TO A NONPARTICIPATING PROVIDER FOR SPECIFIC COVERED HEALTH CARE SERVICES.

(b) IN THE EVENT OF A MATERIAL CHANGE TO THE CARRIER'S NETWORK THAT COULD RESULT IN THE APPLICATION OF SUBPARAGRAPH (I) OF PARAGRAPH (b) OF SUBSECTION (2) OF THIS SECTION, THE CARRIER SHALL PROVIDE NOTICE OF THE CHANGE TO THE COMMISSIONER AT LEAST FIFTEEN DAYS PRIOR TO THE CHANGE. SUCH NOTICE MAY BE PROVIDED BY ELECTRONIC MEANS.

(c) IN THE EVENT THAT A NETWORK OF A MANAGED CARE PLAN WITH OUT-OF-NETWORK BENEFITS THAT IS NOT A HEALTH MAINTENANCE ORGANIZATION OR A HEALTH MAINTENANCE ORGANIZATION WITH A POINT OF SERVICE PLAN CHANGES, AND NOTICE TO COVERED PERSONS IS PROVIDED PURSUANT TO SECTION 10-16-705 (7), SUCH NOTICE SHALL INCLUDE AN UNDERSTANDABLE DISCLOSURE OF:

(I) THE CIRCUMSTANCES UNDER WHICH THE COVERED PERSON MAY BE BALANCE BILLED BY NONPARTICIPATING PROVIDERS; AND

(II) THE MECHANISMS TO OBTAIN THE CARRIER'S REIMBURSEMENT RATE TO NONPARTICIPATING PROVIDERS FOR SPECIFIC COVERED HEALTH CARE SERVICES.

(d) IN THE EVENT THAT A CONTRACT WITH A PARTICIPATING PROVIDER TERMINATES OR IS TERMINATED, NOTIFICATION TO COVERED PERSONS SHALL BE PROVIDED PURSUANT TO SECTION 10-16-705 (7).

(2.7) (a) NOTHING IN SUBSECTION (2) OR (2.5) OF THIS SECTION SHALL DELAY ACCESS TO HEALTH CARE SERVICES.

(b) NOTHING IN SUBPARAGRAPH (I) OF PARAGRAPH (b) OF SUBSECTION (2) OF THIS SECTION SHALL EXEMPT A CARRIER FROM HAVING A PARTICIPATING PROVIDER FOR ALL COVERED BENEFITS. IN ANY CASE WHERE THE CARRIER HAS NO PARTICIPATING PROVIDERS TO PROVIDE A COVERED BENEFIT, THE PROVISIONS OF PARAGRAPH (a) OF SUBSECTION (2) OF THIS SECTION SHALL APPLY.

(10) (a) IN DETERMINING THE REASONABLENESS OF TRAVEL TIME AND DISTANCES FOR THE PURPOSES OF THIS SECTION, CONSIDERATION SHALL BE GIVEN TO DIFFERENCES IN TRAVEL TIMES FOR RURAL AREAS AS OPPOSED TO URBAN AREAS, THE RELATIVE AVAILABILITY OF HEALTH CARE PROVIDERS, THE LOCATION WHERE THE MAJORITY OF PEOPLE IN THE AREA ACCESS NONEMERGENCY SERVICES, AND THE MANAGED CARE PLAN'S GOOD FAITH EFFORTS TO CONTRACT WITH LOCAL PROVIDERS AT REASONABLE RATES.

(b) THE COMMISSIONER, UPON THE COMMISSIONER'S AUTHORITY OR UPON REVIEW OF ONE OR MORE COMPLAINTS, MAY REQUIRE THE CARRIER TO DEMONSTRATE THE ADEQUACY OF THE NETWORK'S PLAN AS SPECIFIED IN SUBSECTION (9) OF THIS SECTION.

(c) THE COMMISSIONER MAY UTILIZE THE REMEDIES OUTLINED IN SECTION 10-3-1108 FOR FAILING TO PROVIDE PROPER DISCLOSURES TO COVERED PERSONS PURSUANT TO SUBSECTION (2) OR (2.5) OF THIS SECTION.

(11) THE DIVISION OF INSURANCE, IN COOPERATION WITH THE CHIEF MEDICAL OFFICER FOR THE STATE, SHALL EVALUATE A CARRIER'S NETWORK ADEQUACY PLAN CONCERNING THE USE OF TELEMEDICINE FOR PROVIDERS WHO ARE SPECIALISTS AND SUB-SPECIALISTS FOR RURAL AREAS. SUCH REVIEW SHALL OCCUR IN A TIMELY FASHION SO AS NOT TO DELAY ACCESS TO HEALTH CARE SERVICES.

SECTION 5. The introductory portion to 10-16-704 (9), 10-16-704 (9) (a), the introductory portion to 10-16-704 (9) (b), and 10-16-704 (9) (b) (V), Colorado Revised Statutes, are amended, and the said 10-16-704 (9) is further amended BY THE ADDITION OF THE FOLLOWING NEW PARAGRAPHS, to read:

10-16-704. Network adequacy. (9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204 (3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan. All

rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract provisions, regardless of whether or not such provisions are also specified in the access plan. The carrier shall prepare an access plan prior to offering a new managed care network and shall update an existing access plan whenever the carrier makes any material change to an existing managed care network, but not less than annually. The access plan OF A CARRIER OFFERING A MANAGED CARE PLAN shall ~~describe or contain at least~~ DEMONSTRATE the following:

(a) ~~The carrier's network, which shall demonstrate the following:~~

~~(I)~~ An adequate number of accessible acute care hospital services, within a reasonable distance or travel time, or both;

~~(II) An adequate number of accessible primary care providers, within a reasonable distance or travel time, or both; and~~

~~(III) An adequate number of accessible specialists and sub-specialists, within a reasonable distance or travel time, or both;~~

(a.3) AN ADEQUATE NUMBER OF ACCESSIBLE PRIMARY CARE PROVIDERS WITHIN A REASONABLE DISTANCE OR TRAVEL TIME, OR BOTH;

(a.5) AN ADEQUATE NUMBER OF ACCESSIBLE SPECIALISTS AND SUB-SPECIALISTS WITHIN A REASONABLE DISTANCE OR TRAVEL TIME, OR BOTH, OR WHO MAY BE AVAILABLE THROUGH THE USE OF TELEMEDICINE;

(a.7) GEOGRAPHIC ACCESSIBILITY, WHICH IN SOME CIRCUMSTANCES MAY REQUIRE THE CROSSING OF COUNTY LINES; AND

(a.9) IF THE COVERED PERSON HAS A PHARMACY BENEFIT, AN ADEQUATE NUMBER OF PHARMACY PROVIDERS WITHIN A REASONABLE DISTANCE, TRAVEL TIME, DELIVERY TIME, OR ALL THREE. NOTHING IN THIS PARAGRAPH (a.9) SHALL PRECLUDE THE USE OF A RETAIL OR MAIL-ORDER PHARMACY PROVIDER.

(b) ~~The carrier's~~ A CARRIER OFFERING A MANAGED CARE PLAN SHALL MAINTAIN procedures for making referrals within and outside its network that, at a minimum, must include the following:

(V) (A) A provision that referrals approved by the plan cannot be retrospectively denied except for fraud or abuse;

(B) A PROVISION THAT REFERRALS APPROVED BY THE PLAN CANNOT BE CHANGED AFTER THE PREAUTHORIZATION IS PROVIDED UNLESS THERE IS EVIDENCE OF FRAUD OR ABUSE.

SECTION 6. Article 16 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PART to read:

PART 8
TASK FORCE TO EVALUATE HEALTH CARE NEEDS FOR COLORADO

10-16-801. Legislative task force - creation - appointments - duties - compensation. (1) A LEGISLATIVE TASK FORCE SHALL BE FORMED TO STUDY AND EVALUATE 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, HEREINAFTER REFERRED TO AS THE "TASK FORCE". THE TASK FORCE SHALL MEET IN THE INTERIM AFTER THE FIRST REGULAR SESSION OF THE SIXTY-THIRD GENERAL ASSEMBLY.

(2) THE TASK FORCE SHALL CONSIST OF TEN MEMBERS WHO ARE CURRENTLY SERVING AS MEMBERS OF THE GENERAL ASSEMBLY AS FOLLOWS:

(a) FIVE SENATORS APPOINTED BY THE PRESIDENT OF THE SENATE, ONE OF WHOM SHALL SERVE AS THE CHAIR OF THE TASK FORCE. NO MORE THAN THREE OF SUCH FIVE MEMBERS SHALL BE FROM THE SAME POLITICAL PARTY, AND THE PRESIDENT OF THE SENATE SHALL CONSULT WITH THE MINORITY LEADER OF THE SENATE IN THE APPOINTMENT OF AT LEAST ONE MEMBER TO THE TASK FORCE.

(b) FIVE REPRESENTATIVES APPOINTED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES, ONE OF WHOM SHALL SERVE AS THE VICE-CHAIR OF THE TASK FORCE. NO MORE THAN THREE OF SUCH FIVE MEMBERS SHALL BE FROM THE SAME POLITICAL PARTY.

(3) THE TASK FORCE SHALL REVIEW THE FOLLOWING ISSUES, INCLUDING, BUT NOT LIMITED TO, THE COST OF AND ACCESS TO HEALTH INSURANCE:

(a) HOW THE RELATIONSHIP BETWEEN HEALTH CARE PROVIDERS AND CARRIERS IS AFFECTING ACCESS TO AND COSTS OF HEALTH INSURANCE COVERAGE, PARTICULARLY IN RURAL AREAS;

(b) 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;

(c) HOW TO CREATE GREATER CHOICE OF HEALTH CARE PLANS FOR ALL SMALL BUSINESSES AT MORE AFFORDABLE RATES, INCLUDING, BUT NOT LIMITED TO, TRENDS IN COPAYMENTS, DEDUCTIBLES, AND OUT-OF-POCKET MAXIMUMS;

(d) HOW MORE AFFORDABLE ACCESS TO AND GREATER CHOICE OF HEALTH INSURANCE FOR ALL SMALL EMPLOYERS MAY BE IMPROVED;

(e) HOW MORE AFFORDABLE ACCESS TO AND GREATER CHOICE OF HEALTH CARE SERVICES MAY BE IMPROVED THROUGH COMPETITION;

(f) THE EXTENT TO WHICH THE "SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY PROGRAM ACT", AS AMENDED BY HOUSE BILL 94-1210, ENACTED AT THE SECOND REGULAR SESSION OF THE FIFTY-NINTH GENERAL ASSEMBLY, AND OTHER STATE LEGISLATION IMPACTED THE SMALL GROUP MARKET;

(g) THE EXTENT TO WHICH THE "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996", 42 U.S.C. SEC. 201, ET SEQ., AS AMENDED, IMPACTED THE SMALL GROUP MARKET;

(h) HOW COLORADO CAN RECRUIT AND RETAIN HEALTH CARE PROFESSIONALS TO RURAL AND URBAN COLORADO;

(i) ANY OTHER TOPIC RELATED TO HEALTH INSURANCE COVERAGE DEEMED NECESSARY BY THE TASK FORCE;

(j) HOW SELF-FUNDED HEALTH INSURANCE PLANS MAY CREATE AN ALTERNATIVE TO MEET HEALTH CARE NEEDS;

(k) WHAT INFLUENCE DOES THE STATE HAVE AS A LARGE EMPLOYER IN THE HEALTH INSURANCE MARKET AND WHAT IS THE FEASIBILITY OF ENROLLING STATE EMPLOYEES INTO PERACARE AS AN ALTERNATIVE TO EXISTING HEALTH BENEFIT PLANS OFFERED TO STATE EMPLOYEES; AND

(l) WHAT ARE THE GENERAL COST FACTORS INVOLVED IN PRESCRIPTION DRUG BENEFITS, INCLUDING, BUT NOT LIMITED TO, COPAYMENTS, DEDUCTIBLE AMOUNTS, OUT-OF-POCKET EXPENSES, AND THE USE OF GENERIC AND NAME BRAND PRESCRIPTION DRUGS.

(4) (a) THE TASK FORCE SHALL HOLD MEETINGS, TAKE PUBLIC TESTIMONY, AND SPONSOR DISCUSSIONS AT VARIOUS LOCATIONS THROUGHOUT THE STATE WITH ANY INTERESTED PARTIES, INCLUDING, BUT NOT LIMITED TO, CONSUMERS, PROVIDERS OF HEALTH CARE SERVICES, PHARMACISTS, INSURANCE PRODUCERS WHO SELL HEALTH INSURANCE PRODUCTS, SMALL BUSINESS REPRESENTATIVES, AND INSURANCE CARRIERS.

(b) THE TASK FORCE SHALL CONDUCT SIX MEETINGS IN RURAL AREAS OF COLORADO AND TWO MEETINGS IN THE DENVER METROPOLITAN AREA. ALL INTERIM COMMITTEE HEARINGS SHALL BE CONCLUDED BY OCTOBER 1, 2001.

(5) THE APPOINTMENTS TO THE TASK FORCE SHALL BE MADE BY JULY 1, 2001. THE FIRST MEETING OF THE INTERIM COMMITTEE SHALL OCCUR DURING THE WEEK OF JULY 15, 2001.

(6) THE STAFF OF THE LEGISLATIVE COUNCIL AND THE OFFICE OF LEGISLATIVE LEGAL SERVICES SHALL BE AVAILABLE TO ASSIST THE TASK FORCE IN CARRYING OUT ITS DUTIES.

(7) THE TASK FORCE SHALL MAKE RECOMMENDATIONS REGARDING THE ISSUES REVIEWED AND, IF NECESSARY, MAY RECOMMEND LEGISLATION. LEGISLATION RECOMMENDED BY THE COMMITTEE SHALL BE TREATED AS LEGISLATION RECOMMENDED BY ANY OTHER LEGISLATIVE INTERIM COMMITTEE FOR PURPOSES OF ANY INTRODUCTION DEADLINES OR BILL LIMITATIONS IMPOSED BY THE JOINT RULES OF THE SENATE AND THE HOUSE OF REPRESENTATIVES.

(8) (a) THE LEGISLATIVE MEMBERS OF THE TASK FORCE SHALL BE COMPENSATED AS PROVIDED IN SECTION 2-2-307, C.R.S., FOR ATTENDANCE AT MEETINGS OF THE

TASK FORCE.

(b) THE TASK FORCE MAY ACCEPT AND EXPEND GIFTS, GRANTS, DONATIONS, AND FEDERAL FUNDS FOR THE PURPOSES OF THIS PART 8.

(9) THE ACTUAL AND NECESSARY EXPENSES, INCLUDING PER DIEM, INCURRED IN THE CONDUCT OF THE TASK FORCE SHALL BE APPROVED BY THE CHAIRPERSON OF THE LEGISLATIVE COUNCIL AND PAID BY VOUCHERS AND WARRANTS DRAWN AS PROVIDED BY LAW FROM FUNDS ALLOCATED TO THE LEGISLATIVE COUNCIL FROM APPROPRIATIONS MADE BY THE GENERAL ASSEMBLY.

SECTION 7. 12-36-106 (1), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

12-36-106. Practice of medicine defined - exemptions from licensing requirements - repeal. (1) For the purpose of this article, "practice of medicine" means:

(g) THE DELIVERY OF TELEMEDICINE THAT MEANS THE DELIVERY OF MEDICAL SERVICES AND ANY DIAGNOSIS, CONSULTATION, TREATMENT, TRANSFER OF MEDICAL DATA, OR EDUCATION RELATED TO HEALTH CARE SERVICES USING INTERACTIVE AUDIO, INTERACTIVE VIDEO, OR INTERACTIVE DATA COMMUNICATION. NOTHING IN THIS PARAGRAPH (g) SHALL BE CONSTRUED TO LIMIT THE DELIVERY OF HEALTH SERVICES BY OTHER LICENSED PROFESSIONALS, WITHIN THE PROFESSIONAL'S SCOPE OF PRACTICE, USING ADVANCED TECHNOLOGY, INCLUDING, BUT NOT LIMITED TO, INTERACTIVE AUDIO, INTERACTIVE VIDEO, OR INTERACTIVE DATA COMMUNICATION.

SECTION 8. 12-36-117 (1), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

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

(jj) ANY ACT OR OMISSION IN THE PRACTICE OF TELEMEDICINE THAT FAILS TO MEET GENERALLY ACCEPTED STANDARDS OF MEDICAL PRACTICE.

SECTION 9. Part 4 of article 4 of title 26, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-420. Telemedicine - legislative intent. (1) IT IS THE INTENT OF THE GENERAL ASSEMBLY TO RECOGNIZE THE PRACTICE OF TELEMEDICINE AS A LEGITIMATE MEANS BY WHICH AN INDIVIDUAL MAY RECEIVE MEDICAL SERVICES FROM A HEALTH CARE PROVIDER WITHOUT PERSON-TO-PERSON CONTACT WITH A PROVIDER.

(2) FOR THE PURPOSES OF THIS SECTION, "TELEMEDICINE" SHALL HAVE THE SAME MEANING AS SET FORTH IN SECTION 12-36-106 (1) (g), C.R.S.

(3) ON OR AFTER JANUARY 1, 2002, FACE-TO-FACE CONTACT BETWEEN A HEALTH CARE PROVIDER AND A PATIENT IN A COUNTY WITH ONE HUNDRED FIFTY THOUSAND RESIDENTS OR LESS MAY NOT BE REQUIRED UNDER THE MANAGED CARE SYSTEM CREATED IN PART 1 OF THIS ARTICLE FOR SERVICES APPROPRIATELY PROVIDED

THROUGH TELEMEDICINE, SUBJECT TO REIMBURSEMENT POLICIES DEVELOPED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING TO COMPENSATE PROVIDERS WHO PROVIDE HEALTH CARE SERVICES COVERED BY THE PROGRAM CREATED IN SECTION 26-4-104. TELEMEDICINE SERVICES MAY ONLY BE USED IN AREAS OF THE STATE WHERE THE TECHNOLOGY NECESSARY FOR THE PROVISION OF TELEMEDICINE EXISTS. THE AUDIO AND VISUAL TELEMEDICINE SYSTEM USED SHALL, AT A MINIMUM, HAVE THE CAPABILITY TO MEET THE PROCEDURAL DEFINITION OF THE MOST RECENT EDITION OF THE CURRENT PROCEDURAL TERMINOLOGY THAT REPRESENTS THE SERVICE PROVIDED THROUGH TELEMEDICINE. THE TELECOMMUNICATIONS EQUIPMENT SHALL BE OF A LEVEL OF QUALITY TO ADEQUATELY COMPLETE ALL NECESSARY COMPONENTS TO DOCUMENT THE LEVEL OF SERVICE FOR THE CURRENT PROCEDURAL TERMINOLOGY FOURTH EDITION CODES THAT ARE BILLED. IF A PERIPHERAL DIAGNOSTIC SCOPE IS REQUIRED TO ASSESS THE PATIENT, IT SHALL PROVIDE ADEQUATE RESOLUTION OR AUDIO QUALITY FOR DECISION MAKING.

(4) THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING SHALL REPORT TO THE HEALTH, ENVIRONMENT, CHILDREN AND FAMILIES COMMITTEE OF THE SENATE AND TO THE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEE OF THE HOUSE OF REPRESENTATIVES NO LATER THAN JANUARY 1, 2006, ON THE APPLICATION OF TELEMEDICINE TO PROVIDE HOME HEALTH CARE; EMERGENCY CARE; CRITICAL AND INTENSIVE CARE, INCLUDING BUT NOT LIMITED TO, NEONATAL CARE; PSYCHIATRIC EVALUATION; PSYCHOTHERAPY; AND MEDICAL MANAGEMENT AS POTENTIAL MANAGED CARE SYSTEM BENEFITS. SUCH REPORT SHALL TAKE INTO ACCOUNT THE AVAILABILITY OF TECHNOLOGY AS OF THE TIME OF THE REPORT TO USE TELEMEDICINE FOR HOME HEALTH CARE, EMERGENCY CARE, AND CRITICAL AND INTENSIVE CARE AND THE AVAILABILITY OF BROADBAND ACCESS WITHIN THE STATE.

(5) THE MANAGED CARE SYSTEM SHALL NOT BE REQUIRED TO PAY FOR CONSULTATION PROVIDED BY A PROVIDER BY TELEPHONE OR FACSIMILE MACHINES.

(6) THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING MAY ACCEPT AND EXPEND GIFTS, GRANTS, AND DONATIONS FROM ANY SOURCE TO CONDUCT THE VALUATION OF THE COST-EFFECTIVENESS AND QUALITY OF HEALTH CARE PROVIDED THROUGH TELEMEDICINE BY THOSE PROVIDERS WHO ARE REIMBURSED FOR TELEMEDICINE SERVICES BY THE MANAGED CARE SYSTEM.

SECTION 10. 25-1-801, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

25-1-801. Patient records in custody of health care facility. (4) FOR THE PURPOSES OF THIS SECTION, MEDICAL INFORMATION TRANSMITTED DURING THE DELIVERY OF HEALTH CARE VIA TELEMEDICINE, AS DEFINED IN SECTION 12-36-106 (1) (g), C.R.S., IS PART OF THE PATIENT'S MEDICAL RECORD MAINTAINED BY THE HEALTH CARE FACILITY.

SECTION 11. 25-1-802, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

25-1-802. Patient records in custody of individual health care providers. (5) FOR THE PURPOSES OF THIS SECTION, MEDICAL INFORMATION TRANSMITTED DURING THE DELIVERY OF HEALTH CARE VIA TELEMEDICINE, AS DEFINED IN SECTION

12-36-106 (1) (g), C.R.S., IS PART OF THE PATIENT'S MEDICAL RECORD MAINTAINED BY A HEALTH CARE PROVIDER.

SECTION 12. 18-13-119 (5) (b), Colorado Revised Statutes, is amended to read:

18-13-119. Health care providers - abuse of health insurance. (5) (b) Health care services are exempt from the provisions of this section if ~~they~~ SUCH HEALTH CARE SERVICES are provided:

(I) In accordance with a contract or agreement between an employer and an employee or employees and the contract includes, as a part of an employee's salary or employment benefits, terms ~~which~~ THAT authorize a practice ~~which~~ THAT would otherwise be prohibited by subsection (3) of this section; OR

(II) IN ACCORDANCE WITH A CONTRACT OR AGREEMENT BETWEEN A TOWN, CITY, CITY AND COUNTY, OR MUNICIPALITY OR A SPECIAL HEALTH ASSURANCE DISTRICT PURSUANT TO SECTION 31-15-302 (1), C.R.S., UNDER TERMS THAT AUTHORIZE A PRACTICE THAT WOULD OTHERWISE BE PROHIBITED BY SUBSECTION (3) OF THIS SECTION.

SECTION 13. 31-15-302 (1), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

31-15-302. Financial powers - legislative declaration - repeal. (1) The governing bodies in municipalities shall have the following general powers in relation to the finances of the municipality:

(i) (I) FOR A MUNICIPALITY THAT HAS A POPULATION OF TWENTY THOUSAND OR FEWER RESIDENTS, TO ENTER INTO CONTRACTS WITH A PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT WHO IS LICENSED IN THIS STATE TO PROVIDE HEALTH CARE SERVICES TO SUCH MUNICIPALITY. SUCH HEALTH CARE PROVIDERS SHALL BE KNOWN AS "COMMUNITY CONTRACTED HEALTH CARE PROVIDERS".

(II) THE GENERAL ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT ACCESS TO HEALTH CARE SERVICES IN RURAL AREAS IS AN INCREASING PROBLEM IN COLORADO. SOME RURAL COLORADANS DO NOT HAVE ACCESS TO A PRIMARY CARE PROVIDER IN THEIR TOWN AND ARE FORCED TO TRAVEL. IT IS THE INTENT OF THE GENERAL ASSEMBLY TO EASE THE STRAIN ON RURAL COLORADAN'S HEALTH CARE NEEDS BY ALLOWING A MUNICIPALITY WITH TWENTY THOUSAND OR FEWER RESIDENTS TO CONTRACT WITH A PHYSICIAN, A NURSE PRACTITIONER, OR A PHYSICIAN'S ASSISTANT TO PROVIDE HEALTH CARE SERVICES TO RURAL AREAS. IT IS THE INTENTION OF THE GENERAL ASSEMBLY TO REVIEW THE SUCCESS OF SUCH MUNICIPALITIES' EFFORTS AS AUTHORIZED BY SUBPARAGRAPH (I) OF THIS PARAGRAPH (i) TO DETERMINE THE EFFECTIVENESS OF THE PROGRAM.

(III) THIS PARAGRAPH (i) IS REPEALED, EFFECTIVE JULY 1, 2008.

SECTION 14. Part 10 of article 1 of title 32, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

32-1-1003.5. Health assurance districts - additional powers - repeal. (1) THE GENERAL ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT ACCESS TO HEALTH CARE SERVICES IN RURAL AREAS IS AN INCREASING PROBLEM IN COLORADO. SOME RURAL COLORADANS DO NOT HAVE ACCESS TO A PRIMARY CARE PROVIDER IN THEIR TOWN AND ARE FORCED TO TRAVEL. IT IS THE INTENT OF THE GENERAL ASSEMBLY TO EASE THE STRAIN ON RURAL COLORADAN'S HEALTH CARE NEEDS BY ALLOWING A SPECIAL DISTRICT TO BE CREATED TO DIRECTLY CONTRACT WITH A PHYSICIAN, A NURSE PRACTITIONER, OR A PHYSICIAN'S ASSISTANT TO PROVIDE HEALTH CARE SERVICES TO RURAL AREAS. IT IS THE INTENTION OF THE GENERAL ASSEMBLY TO REVIEW THE SUCCESS OF SUCH EFFORTS AS AUTHORIZED BY SUBSECTION (2) OF THIS SECTION TO DETERMINE THE EFFECTIVENESS OF THE PROGRAM.

(2) IN ADDITION TO THE POWERS SPECIFIED IN SECTION 32-1-1001, THE BOARD OF ANY HEALTH ASSURANCE DISTRICT HAS ANY OR ALL OF THE FOLLOWING POWERS FOR AND ON BEHALF OF SUCH DISTRICT:

(a) TO ORGANIZE, OPERATE, CONTROL, DIRECT, MANAGE, CONTRACT FOR, OR FURNISH HEALTH CARE SERVICES FROM A PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT LICENSED IN THIS STATE AND SUCH HEALTH CARE PROVIDER SHALL BE KNOWN AS A''COMMUNITY CONTRACTED HEALTH CARE PROVIDER'';

(b) TO DRAW WARRANTS AGAINST HEALTH ASSURANCE DISTRICT FUNDS HELD BY THE COUNTY TREASURER FOR THE PURPOSES SET FORTH IN PARAGRAPH (a) OF THIS SUBSECTION (2).

(3) THE BOARD OF COUNTY COMMISSIONERS OF ANY COUNTY OR THE GOVERNING BODY OF ANY MUNICIPALITY WITHIN THE HEALTH ASSURANCE DISTRICT MAY TRANSFER ANY REAL AND PERSONAL PROPERTY, WHETHER OR NOT THERETOFORE USED BY THE COUNTY OR MUNICIPALITY FOR HOSPITAL PURPOSES, TO ANY NEWLY ORGANIZED HEALTH ASSURANCE DISTRICT IF SUCH REAL AND PERSONAL PROPERTY IS LOCATED IN THE NEWLY ORGANIZED DISTRICT.

(4) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2008.

SECTION 15. 24-34-104 (39) (b), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBPARAGRAPH to read:

24-34-104. General assembly review of regulatory agencies and functions for termination, continuation, or reestablishment. (39) (b) The following agencies, functions, or both, shall terminate on July 1, 2008:

(XII) REVIEW OF THE USE OF COMMUNITY CONTRACTED HEALTH CARE PROVIDERS PURSUANT TO SECTION 31-15-302 (1), C.R.S., AND 32-1-1003.5, C.R.S., BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT IN COOPERATION WITH THE DEPARTMENT OF REGULATORY AGENCIES.

SECTION 16. No appropriation. The general assembly has determined that this act can be implemented by the division of insurance within the department of regulatory agencies within existing appropriations, and therefore no separate appropriation to the division of insurance within the department of regulatory agencies of state moneys is necessary to carry out the purposes of this act.

SECTION 17. Effective date - applicability. (1) Except as otherwise provided in subsection (2) of this section, this act shall take effect January 1, 2002, and shall apply to health benefit policies issued or renewed on or after said date; provider-sponsored networks formed on or after said date; and the practice of telemedicine on or after said date.

(2) (a) Section 6 shall not take effect if House Bill 01-1240, House Joint Resolution 01-1011, House Joint Resolution 01-1027, and House Joint Resolution 01-1050 are adopted at the First Regular Session of the Sixty-third General Assembly. If said house bill or any of the house joint resolutions are not adopted, said section 6 shall take effect upon passage.

(b) Sections 12, 13, 14, 16, 17, and 18 shall take effect upon passage and shall apply to community contracted health care providers providing services for a city, city and county, town, municipality, or special health assurance district formed after said date.

SECTION 18. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: June 5, 2001